

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06398**

6414

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		d. STREET ADDRESS <b>1400 Eastern Blvd. Balto.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>400 Eastern Blvd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>RUBY E ABSALOM</b>				4. DATE OF DEATH Month Day Year <b>June 7 19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-8-93</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Adams</b>				14. MOTHER'S MAIDEN NAME <b>Nanny Low</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>[If yes, give war or dates of service]</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Husband (Same as above)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Art. Scler.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema</b>						INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Jack C. Collins</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6-7-61</b>	
EXAMINER'S NAME (Type) <b>JACK C. COLLINS</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-10-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connelly</b>				ADDRESS <b>418 Eastern Blvd.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 8 '61</b>	
						24b. REGISTRAR'S SIGNATURE <b>Charles S. Farris</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6415											
66399											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>45 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2606 Lauretta Avenue (23)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>CHARLES B. AFFAYROUX</b>						4. DATE OF DEATH Month Day Year <b>June 12 19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 15, 1915</b>		9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days <b>12 19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stationary Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frank J. Affayroux</b>						14. MOTHER'S MAIDEN NAME <b>Lydia Murphy</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>						16. SOCIAL SECURITY NO. <b>219-05-7477</b>					
17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b>						Address <b>Fort Howard Division</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA, PANCREAS WITH CARCINOMATOSIS</b> (c) <b>DUODENAL ULCER</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>April 28 8:15</b> to <b>June 12 1961</b> , that <b>he</b> (we) last saw the deceased alive on <b>June 12 1961</b> , and that death occurred at <b>A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Thomas F. Crahan</b> 22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>					
22b. DATE SIGNED <b>6/12/61</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-15-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City, town or county)		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14</b>				ADDRESS <b>Baltimore 28, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

00332

(M)

1000 Howard  
Veterans Administration Hospital  
2000 Lawrence Avenue (S2)

August 19, 1952  
Calverton, Maryland  
U. S. A.

1  
James L. Thompson  
Clinical Research, Veterans Administration  
1000 Howard Avenue

Calverton, Maryland  
U. S. A.

June 12, 1952  
April 12, 1952

Mr. Cook-Bright, Inc., 8000 Kettering Rd., Toledo, Ohio  
Mr. Thompson, U. S. A.  
Veterans Administration Hospital  
Calverton, Maryland



1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

6416

06400

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>			
c. LENGTH OF STAY IN 1b <b>1 1/2 mo</b>				d. STREET ADDRESS <b>4021 Payers Mill Road</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HENRY</b> First Middle Last				4. DATE OF DEATH Month <b>6</b> Day <b>24</b> Year <b>1961</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>N</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3. 11. 1917</b>	
9. AGE (In years last birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>24</b> Hours <b>15</b> Min.		11. IF UNDER 24 HRS. Months <b>4</b> Days <b>24</b> Hours <b>15</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>South Carolina</b>			
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>SUMTER ALLEN</b>				14. MOTHER'S MAIDEN NAME <b>ROZIE ISAAC</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>(?)</b>			
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>For advanced pulmonary tuberculosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>002X</b> <b>DUE TO</b> <b>Diabetes mellitus</b> <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Diabetes mellitus</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>5. 9. 1961</b> to <b>6. 24. 1961</b> , that (I) (we) last saw the deceased alive on <b>6. 24. 1961</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm. Newcomer</b>				22b. DATE SIGNED <b>6. 24. 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>				22d. ADDRESS <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-28-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial</b>		23d. LOCATION (City, town, or county) (State) <b>Sandy Spring, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>				25a. REC'D BY REGISTRAR <b>June 30 '61</b>			
ADDRESS <b>Rockville, Md.</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

00030

STATE OF TEXAS

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1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06401

1. PLACE OF DEATH a. COUNTY <i>Balto</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Bradshaw Rd</i>		d. STREET ADDRESS <i>11624 Dorsey Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>William Phillip Amrhein</i>		4. DATE OF DEATH Month <i>June</i> Day <i>4</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-5-07</i>
9. AGE (In years last birthday) <i>54</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber - Sup.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Inspector</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Philip Amrhein</i>		14. MOTHER'S MAIDEN NAME <i>Augusta Scifer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>216-10-872</i>	
17. INFORMANT <i>Wife (Same as above)</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Acute Cor. Thromb. Sudden</i> Conditions, if any, which gave rise to immediate cause (b) <i>2</i> (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank T. Kasik</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK T. KASIK</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>6-8-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemers</i>
22d. LOCATION (City, town, or county) <i>Balto.</i>		(State) <i>MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Connelly</i>		ADDRESS <i>418 Eastern Blvd.</i>	
24a. REC'D BY REGISTRAR DATE <i>JUN 7 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 2. Give Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 32  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Date of Death: \_\_\_\_\_

6. Place of Death: \_\_\_\_\_

7. Cause of Death: \_\_\_\_\_

8. Manner of Death: \_\_\_\_\_

9. Signature of Medical Examiner: \_\_\_\_\_

10. Signature of Coroner: \_\_\_\_\_

11. Signature of Registrar: \_\_\_\_\_

12. Signature of Undertaker: \_\_\_\_\_

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

6418

06402

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Forest Haven Nursing Home</b>		d. STREET ADDRESS <b>14 W. 2nd Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Arkuszewski</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>24</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 29, 1889</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seaboard Asphalt</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John Arkuszewski</b>		14. MOTHER'S MAIDEN NAME <b>Rosalie Golenbiewski</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>213-05-4036</b>	
17. INFORMANT <b>Mrs. Catherine Arkuszewski</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIO-SCLEROTIC CHANGING VASCULAR</b> DUE TO (c) <b>HYPERTENSION - ACUTE LEFT VENTRICULAR FAILURE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/1</b> 19 <b>61</b> to <b>6/24</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>6/24</b> 19 <b>61</b> , and that death occurred at <b>2:00 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John H. Shaw</b>		22b. DATE <b>June 26, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>John H. Shaw</b>		22d. ADDRESS <b>5800 Edmondson Ave.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 28, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Ritchie Hwy. A. A. Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Hwy. (25)</b>	
25a. REC'D BY REGISTRAR <b>JUN 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Wm. J. H. H.</b>	

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UNITED STATES OF AMERICA

1913

(M)

STATE OF NEW YORK  
IN SENATE  
January 15, 1913.  
REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1912.  
ALBANY:  
J. B. LEECH, STATE PRINTER.  
1913.

OFFICE OF THE  
COMMISSIONER OF THE  
LAND OFFICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6419

Item 23b, Film G290 7/3/61 jwk

06403

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>9 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1120 Arran Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HOMER J. ARNREICH</b>				4. DATE OF DEATH <b>June 26 19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 18, 1891</b>	
9. AGE (In years last birthday) <b>69 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>							
13. FATHER'S NAME <b>Ferdinand M. Arnreich</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte A. Johnston</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW I</b>				16. SOCIAL SECURITY NO. <b>219-10-0752</b>			
17. INFORMATION <b>Clinical Records, VAH, Baltimore 18, Maryland</b>				18. ADDRESS <b>Fort Howard Division</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, TERMINAL</b> DUE TO (b) <b>BLEEDING PEPTIC ULCER, DUODENUM</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>XXXXXX</b> (c) <b>PORTAL CIRRHOSIS OF LIVER</b> INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>ARTERIOSCLEROTIC HEART DISEASE Duration unknown</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 17 19 61</b> to <b>June 26 19 61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 26 19 61</b> , and that death occurred at <b>9:15 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Thomas F. Crahan</b> THOMAS F. CRAHAN, M.D.				22b. DATE SIGNED <b>6/26/61</b>		22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>	
22d. ADDRESS <b>VAH, BALTO. 18, MD., FT. HOWARD DIVISION</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 29, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck &amp; Son, 5305 Harford Rd., Balto.</b>				25a. REC'D BY REGISTRAR <b>JUN 28 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
				14, Md.			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> c. LENGTH OF STAY IN 1b <u>2 days</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dept Nursing Home</u>		d. STREET ADDRESS <u>4213 Granada Ave</u>	
3. NAME OF DECEASED (Type or print) <u>JEANNETTE A. AUERBACH</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1888</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Byer</u>		12. KIND OF BUSINESS OR INDUSTRY <u>clothes</u>	
13. BIRTHPLACE (State or foreign country) <u>New York City</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>Unknown</u>		16. MOTHER'S MAIDEN NAME <u>Adler</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. <u>6-8-61</u>	
19. INFORMANT <u>Mrs. Betty Strauss</u>		Address <u>Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>Myocardial Decompensation</u> (b) <u>Coronary Insufficiency</u> DUE TO <u>420</u> (c) <u>4 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-6-61</u> to <u>6-8-61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6-8-61</u> , 19 <u>61</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>James G. Saffell</u>		22b. DATE SIGNED <u>6-8-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>James G. Saffell</u>		22d. ADDRESS <u>Reisterstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Univ Hosp</u>		23b. DATE THEREOF <u>June 9/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Anatomy Board of U. Hosp.</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sol. Levinson &amp; Bros. Inc.</u>		25a. REC'D BY, REGISTRAR <u>Charles S. Kline</u>	
ADDRESS <u>6010 Reist Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	
DATE <u>JUN 13 '61</u>			

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SHERIFF  
COUNTY OF  
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TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										06405	
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point 19, Md.</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Bethlehem Steel Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1237 N. Potomac Street</b>					
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>J.</b> Last <b>Baker</b>						4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>1961</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/25/89</b>		9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pump Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>				11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Baker</b>						14. MOTHER'S MAIDEN NAME <b>Mary Schafer</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>						16. SOCIAL SECURITY NO. <b>213-09-1576</b>		17. INFORMANT <b>Hattie Johnson Baker, wife, above</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>420-1</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Generalized Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)										INTERVAL BETWEEN ONSET AND DEATH <b>1 minute</b> <b>16 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
21. ACTUAL SIGNATURE <b>Jack E Collins</b>						21. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>6-10-61</b>					
21. EXAMINER'S NAME (Type) <b>Jack E Collins</b>						Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6/13/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faity</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR <b>Charles E. Schimunek Funeral Home</b> ADDRESS <b>3331 Brehms Lane</b>						24a. REC'D BY REGISTRAR <b>JUN 13 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kross</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
06406											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b> c. LENGTH OF STAY IN 1b <b>33 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rosewood St. Tr. School</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> g. STREET ADDRESS <b>Unknown</b> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Katie</b> First Middle Last						4. DATE OF DEATH <b>6</b> <b>5</b> <b>1961</b> Month Day Year					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/29/1878</b>		9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore City, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMATION Address <b>Rosewood Records, Owings Mills, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction of myocardium due to arteriosclerotic coronary thrombosis.</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420-0</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive vascular disease with cardiac failure (compensated)</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>12-31-</b> , 19 <b>27</b> to <b>6-5-</b> , 19 <b>61</b> that <del>the</del> (we) last saw the deceased alive on <b>6/5/</b> , 19 <b>61</b> , and that death occurred at <b>9:30, P.M.</b> the causes and on the date stated above.											
22a. SIGNATURE <b>Edward J. Mathews</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>Edward J. Mathews, M.D.</b>						22d. ADDRESS <b>Rosewood State Training School</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>June 12/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Roswood</b>		23d. LOCATION (City, town or county) (State) <b>Owings Mills Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Elmer, Sr. Roswood Md</b>						ADDRESS		25a. REC'D BY REGISTRAR <b>JUN 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Carlton S. Keene</b>	

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How often in case of a fire in the building?

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See self for details

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6423  
 BALTIMORE COUNTY  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06407

1. PLACE OF DEATH a. COUNTY <b>BENT NURSING HOME REISTERSTOWN</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>BALTO.</b> b. COUNTY <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <b>May 23, 1961</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>md</b> <b>3401-4</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BENT NURSING HOME 12020 REISTERSTOWN RD.</b>		d. STREET ADDRESS <b>1104 STODDARD CT.</b>	
3. NAME OF DECEASED (Type or print) First <b>Blanche</b> Middle <b>BARNES</b> Last <b>BARNES</b>		4. DATE OF DEATH Month <b>6</b> Day <b>21</b> Year <b>1961</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1887</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>md</b>	9. AGE (In years lost birthday) yrs. <b>74</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <b>md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>I</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charles Barnes 1104 Stoddard</b>		Address <b>er</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Edema Lungs</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Chronic Myocarditis with Dilatation</b> DUE TO (c) <b>Arteriosclerotic Cardio-Vascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 days</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none; Parkinsonism</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 25, 1961</b> to <b>June 21, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 19, 1961</b> , and that death occurred at <b>7:55 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>George C. Medaury</b>		22b. DATE SIGNED <b>June 21, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>George C. Medaury Md</b>		22d. ADDRESS <b>230 main St., Reisterstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>6-24-61</b>		23b. DATE THEREOF <b>md</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>mt calhoun</b>		23d. LOCATION (City, town, or county) (State) <b>md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George S. Nelson</b>		25a. REC'D BY REGISTRAR <b>1348 N. Calhoun St</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>		DATE <b>26 '61</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6424  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06408

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN b <b>212 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b> d. STREET ADDRESS <b>Route #1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN M. BARNES</b>		4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>1901</b>		9. AGE (In years last birthday) <b>59 yrs.</b>		IF UNDER 1 YEAR Months <b>10</b> Days <b>28</b> IF UNDER 24 HRS. Hours <b>19</b> Min. <b>61</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stone Mason</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick County, Maryland</b>			
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>							
13. FATHER'S NAME <b>Joshua T. Barnes</b>		14. MOTHER'S MAIDEN NAME <b>(Martha) Bertha Boone</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 215-18-7392</b>		17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Md. FORT HOWARD DIVISION</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC CARCINOMATOSIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SURGICAL ABSENCE, RIGHT KIDNEY (CARCINOMA, RIGHT KIDNEY)</b>				INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>180X</b>			
20f. (City or town) <b>June 28, 1961</b>		20g. (County) <b>Carroll</b>		20h. (State) <b>Md.</b>			
21. I certify that <b>JOHN</b> (this hospital) attended the deceased from <b>November 28, 1960</b> , to <b>June 28, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 28, 1961</b> , and that death occurred at <b>9:10 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Thomas F. Crahan</b>		22b. DATE SIGNED <b>6/29/61</b>		22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>			
22d. ADDRESS <b>VAH, BALTO. 18, MD., FORT HOWARD DIVISION</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-1-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>(Providence) Calvary Methodist Church</b>			
23d. LOCATION (City, town or county) <b>Carroll County, Maryland</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Waltz Funeral Home, Winfield, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUL 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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February 10, 1961

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URGENT 1-11-61 (CAROLINA, REBEL KIDNEY)

URGENT 1-11-61

URGENT 1-11-61



## CERTIFICATE OF DEATH

Reg. Dist. No. **06409**

6425

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Pennsylvania</b> b. COUNTY <b>York</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenarm</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenarm Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ALMA</b> Last <b>BEATTY</b>		4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 29, 1881</b>
9. AGE (In years last birthday) yrs. <b>79</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>	
11. BIRTHPLACE (State or foreign country) <b>Harford Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Edward Beatty</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Rebecca Pocock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>195-26-8052</b>	
17. INFORMANT <b>Miss. Lela M. Beatty</b>		Address <b>Glenarm, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>General Cardiovascular Sclerosis</b> DUE TO (c) <b>10 y</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 11, 1961</b> , to <b>June 11, 1961</b> , that I last saw the deceased alive on <b>June 11, 1961</b> , and that death occurred at <b>11:15 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clifford F. Hudson, M.D.</b>		DATE SIGNED <b>June 11, 1961</b>	
PHYSICIAN'S NAME (Type) <b>CLIFFORD F. HUDSON</b>		<b>FORK, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/14/1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer</b>	22d. LOCATION (City, town, or county) (State) <b>Rutledge Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Kurtz</b>		24a. REC'D BY REGISTRAR <b>June 13 '61</b>	
ADDRESS <b>Farmersville Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Clifford F. Hudson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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(M)

Blank certificate form with faint, mirrored text visible through the paper. The text is illegible due to the quality of the scan and the nature of the document.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6426

06410

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>27 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Delaware</b> <span style="float: right;">b. COUNTY <b>Kent</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smyrna</b> <span style="float: right;">46X-3</span> d. STREET ADDRESS <b>36 Mt. Vernon Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>PAUL</b> <span style="float: right;">Middle</span>		<b>4. DATE OF DEATH</b> Last <b>BEGLEY</b> <span style="float: right;">Month <b>June</b> Day <b>14</b> Year <b>19 61</b></span>		<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>August 16, 1921</b> <span style="float: right;">39 yrs.</span>		<b>9. AGE</b> (In years last birthday) <b>39</b> <span style="float: right;">IF UNDER 1 YEAR: Months <b>14</b> Days <b>19</b> Hours <b>61</b> Min.</span>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Mechanic</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Aircraft</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Lee County, Kentucky</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>									
<b>13. FATHER'S NAME</b> <b>Perry Begley</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Birdie Jones</b>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <span style="float: right;">(If yes, give word or dates of service) <b>WW II</b></span>				<b>16. SOCIAL SECURITY NO.</b> <b>400-14-9752</b>				<b>17. INFORMANT</b> <span style="float: right;">Address</span> <b>Clinical Records VA Hospital, Baltimore 18, Md.</b> <b>Fort Howard Division</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>178X METASTATIC EMBRYONAL CARCINOMA, WIDESPREAD</b> (b) <b>XXXX (PRIMARY SITE: TESTIS)</b> (c) <b>XXXXX BRONCHOPNEUMONIA, TERMINAL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>XXXXX PEPTIC ULCER, DUODENUM</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>  <b>RECENT</b>  <b>UNKNOWN</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 18</b> <b>19 61</b> to <b>June 14</b> <b>19 61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 14</b> <b>19 61</b> , and that death occurred at <b>12:10</b> <b>P.</b> , from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <b>Thomas F. Crahan</b> <span style="float: right;">M.D.</span>						<b>22b. DATE SIGNED</b> <b>6/15/61</b>							
<b>22c. PHYSICIAN'S NAME</b> (Type or print) <b>THOMAS F. CRAHAN, M.D.</b>						<b>22d. ADDRESS</b> <b>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>				<b>23b. DATE THEREOF</b> <b>6-16-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Camp Nelson National</b>				<b>23d. LOCATION</b> (City, town or county) (State) <b>Nicholasville, Kentucky</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.</b>						<b>25a. REC'D BY REGISTRAR</b> <b>JUN 20 '61</b>							
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>													

MEDICAL CERTIFICATION

2

1

The law requires that the death certificate be completed within 24 hours after death. The law requires that the death certificate be completed within 24 hours after death. The law requires that the death certificate be completed within 24 hours after death.

shipped to

Betts & West Funeral Home, 404 N. Main St. Nicholasville, Ky.



Address

Business

Name

Fort Howard

St. Louis

St. Louis

Veterans Administration Hospital

30 Mc. Vernon Street

PAUL

ROBERT

June

August 10, 1951

WILLIS

Male

Atlanta

Las Conchas, Kentucky

U. S. A.

Fort Kelly

Little Jones

Clinical Records, Veterans Administration Hospital, St. Louis, Mo.  
Fort Howard Division

WILLIS

Yes

WILLIS

Metastatic Carcinoma, Widespread

UNKNOWN

(Primary Site: Testis)

BRONCHOPNEUMONIA, TERMINAL

UNKNOWN

PEPTIC ULCER, DUODENAL

UNKNOWN

WILLIS

MAY 18

June 24

June 24

THOMAS A. GIBSON, M.D.

VAN BASTHORN, JR., MARYLAND, FT. HOWARD DIV.

Received

Group Health Section

Administrative Section

Mr. Cook-Rights, Inc., 6000 Hartford Rd., Baltimore 14, Md.

Letter to West Farmington Home, 822 N. Main St., Indianapolis, Ind.

## CERTIFICATE OF DEATH

Reg. Dist. No.

06411

6427

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Monkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Monkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Big Falls Rd.</u>		d. STREET ADDRESS <u>Big Falls Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Banks</u> Middle <u>H.</u> Last <u>Berry</u>		4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16, 1906</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>4</u> Hours <u>54</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Peru Lack, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edgar Banks</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Hollicamp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>186-032940</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF BODY OF PANCREAS</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>61</u> to <u>June 20</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>June 19</u> , 19 <u>61</u> , and that death occurred at <u>8:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>HAMPSTEAD, MD</u> DATE SIGNED <u>6-21-61</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u>		<u>Hampstead, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-23-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fosters Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Monkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

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CENTRAL CITY, OHIO

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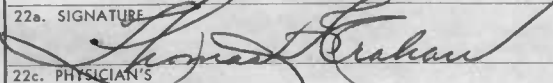
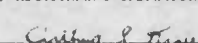
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6428

06412

<b>1. PLACE OF DEATH</b> a. COUNTY <b>V Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>5 1/4 Hours</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Freedom</b> d. STREET ADDRESS <b>Bentley Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>SAMUEL BIRKMAIER</b> First Middle Last			<b>4. DATE OF DEATH</b> <b>June 7 19 61</b> Month Day Year				
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>January 23, 1900</b>		<b>9. AGE</b> (In years last birthday) <b>61</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Night Watchman</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Country Club</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>					
<b>13. FATHER'S NAME</b> <b>Frederick J. Birkmaier</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Hueston</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>WW II</b> <b>218-09-7261</b> (If yes give war or dates of service)							
<b>16. SOCIAL SECURITY NO.</b> <b>218-09-7261</b>							
<b>17. INFORMANT</b> <b>Clinical Records, VA Hospital, Baltimore 18, Md. Fort Howard Division</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY THROMBOSIS</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>					INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b> <b>7 DAYS</b> <b>UNKNOWN</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Pulmonary Edema.- 1 Day Duration</b>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that</b> <b>he</b> (this hospital) attended the deceased from <b>4:PM 6/7/61</b> to <b>June 7, 1961</b> , that <b>he</b> (we) last saw the deceased alive on <b>June 7, 1961</b> , and that death occurred at <b>9:15 P.M.</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b>  <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Thomas F. Crahan, M. D.</b>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>22d. ADDRESS</b> <b>VAH, Baltimore 18, Md., Ft. Howard Division</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>6-10-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Parkwood Cemetery</b>			
<b>23d. LOCATION</b> (City, town or county) <b>Baltimore, Maryland</b>		<b>23e. (State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JUN 12 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6429

06413

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore-Catonsville</u> c. LENGTH OF STAY IN 1b <u>9 S. Beechwood Road</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>9 S. Beechwood Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Martha C. Blackman</u>				4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 31, 1888</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Darskadon</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Bahl</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mrs. Jean Todd-8421 Lynch Road-Dundalk-22, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic, hypertensive cardiovascular disease</u> 443X DUE TO (b) _____ Conditions, any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs +</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (the hospital) attended the deceased from <u>1953</u> , 19____, to <u>June 7</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>June 6</u> , 19 <u>61</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John A. Nesbitt, Jr.</u> M.D.				22b. DATE SIGNED <u>6-8-61</u>		22c. PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR.</u>	
22d. ADDRESS <u>1118 St Paul St. Balto. 2, Md.</u>				23a. REC'D BY REGISTRAR DATE <u>JUN 9 '61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>6-9-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>North Penna Aves Baltimore 17, Md.</u>		23d. LOCATION (City, town or county) (State) <u>Keyser, West Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tickner &amp; Sons</u>				25b. REGISTRAR'S SIGNATURE <u>Wm J. Tickner</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

00413

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

6430  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

Item 23b, Film G208 6/21/61 1wk

06414

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1mo. 1 wk.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Route 3</b>		d. STREET ADDRESS <b>Clinton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>William</b> Last <b>BLADEN</b>		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 17, 1878</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>14</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(Retired) Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM BLADEN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>YES.</b>	
17. INFORMANT <b>Records, Spring Grove State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH hours years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 8, 1961</b> to <b>June 16, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 16, 1961</b> , and that death occurred on <b>5:35 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Jose R. Arizaga</b>		22b. DATE SIGNED <b>6/14/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSE R. ARIZAGA, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSP.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>June 20, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>BLADENSBURG, MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co. Pimlico, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 19 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur E. Knepper</b>			





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06415

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2910 POTTY HILL AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>William</u> Last <u>BLAKELEY</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>23</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 12 - 1903</u>		9. AGE (In years last birthday) <u>57</u> yrs.	10. IF UNDER 1 YEAR Months <u>57</u> Days <u>57</u> Hours <u>57</u> Min. <u>57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTRACTORS</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Blakeley</u>				14. MOTHER'S MAIDEN NAME <u>Sarah L.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-5359</u>		INFORMANT <u>Annie Blakeley</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>undetectable</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> to <u>6-22</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6-23</u> , 19 <u>61</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>7122 Hartford Rd Baltimore Md</u>			
PHYSICIAN'S NAME (Type) <u>DR JOS. SKLOVEN</u>				DATE SIGNED <u>6.23.61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 26 - 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS F EVANS + Son</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 26 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **06416**

6432

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X BALTIMORE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1448 CLAIRIDGE RD.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>FLORENCE MAE BLANTZ</b>			4. DATE OF DEATH Month Day Year <b>JUNE 16, 1961</b>				
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 29, 1889</b>	9. AGE (In years last birthday) yrs. <b>71</b>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>RICHARD H. BRADY</b>				14. MOTHER'S MAIDEN NAME <b>EMMA V. HARWAY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MR. JOHN W. BLANTZ</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>General Carcinomatosis</b> <b>170X</b> DUE TO <b>Carcinoma of Rt. breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>2 1/2 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1916</b> to <b>6/16</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>6/15</b> , 19 <b>61</b> , and that death occurred on <b>8:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Eliot W. Johnson</b> M.D.				ADDRESS (Street, city or town, state) <b>3432 Madison Ave Baltimore 29 Md</b>			
DATE SIGNED <b>6/17/61</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>6/20/1961</b>		<b>Cedar Bluff Cem.</b>		<b>ANNAPOLIS Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. L. Schwalb</b>				ADDRESS <b>3512 Frederick Ave. (29)</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 19 61</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. L. H. H. H.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

6433

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06417

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>87 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>L.</b> Last <b>BLUM</b>		4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1874</b>
9. AGE (In years lost birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months <b>87</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Truck Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Blum</b>		14. MOTHER'S MAIDEN NAME <b>Catherine ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. John C. Gonce Sr.</b>		Address <b>Catonsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute &amp; chronic Congestive Heart Failure</b> DUE TO (b) <b>Degenerative Heart Disease</b> DUE TO (c) <b>Pulmonary Embolism</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18a)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 1961</b> to <b>6/25/61</b> , that (I) <b>( )</b> last saw the deceased alive on <b>6/24/61</b> , and that death occurred at <b>9:30 P. M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>6/27/61</b>	
22a. SIGNATURE <b>W. E. McGrath M. D.</b>		22c. PHYSICIAN'S NAME (Type) <b>W. E. McGrath M. D.</b>	
22d. ADDRESS <b>1303 Frederick Rd. Catonsville - 28, Md.</b>		22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/28/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 28 '61</b>	
ADDRESS <b>Catonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Evans</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06418

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shady Nook Nursing Home</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X W Owings Mills</u> d. STREET ADDRESS <u>24 Lastgate Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Elizabeth</u> First Middle Last <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>July 26, 1878</u> <b>9. AGE</b> (In years last birthday) <u>82</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		<b>4. DATE OF DEATH</b> <u>June 13, 1961</u> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Baltimore</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Joseph Brooks</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth ?</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>No</u> <b>17. INFORMANT</b> <u>Mr. W. T. Brooks, 24 Lastgate Rd.</u> Address		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>450.0</u> IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis Ge</u> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>May 12, 1961</u> <b>to</b> <u>May 13, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>May 12, 1961</u> , <b>and that death occurred at</b> <u>11:58</u> <b>M, from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <u>Wetherbee Fort</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Wetherbee Fort</u> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <u>6/14/61</u> <b>22b. DATE SIGNED</b> <u>1158 St. Paul &amp; Balto. Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>6/16/61</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore</u> <u>Md.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. J. Tiebner &amp; Sons</u> <u>Baltimore, Md.</u> <b>25a. REC'D BY REGISTRAR</b> <u>JUN 16 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Carles L. Kraus</u>	

00018

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6435

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06419

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. LENGTH OF STAY IN 1b <b>(22)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2908 Yorkway</b>				d. STREET ADDRESS <b>2908 Yorkway</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>LeRoy Wellington Brown, Sr.</b>				4. DATE OF DEATH Month Day Year <b>June 29th, 1961</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 22, 1913</b>		9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipefitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frederick J. Brown</b>				14. MOTHER'S MAIDEN NAME <b>Superior Keffer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>219-01-2868</b>		17. INFORMANT Address <b>Emma G. Brown same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>A-S-C-V Disease</b> (c) <b>Dissection</b> DUE TO cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M B Davis</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/30/61</b>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/3/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk 22, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur P. H...</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6436

## CERTIFICATE OF DEATH

Reg. Dist. No. 06420

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Oella, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u>		d. STREET ADDRESS <u>75 Oella Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mabel</u> First <u>Butler</u> Middle <u>Butler</u> Last		4. DATE OF DEATH <u>June 14</u> Month <u>June</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/2/1888</u>
9. AGE (In years last birthday) <u>72</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Romulus Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Emma Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Lillian Miller</u>		75 Oella Ave, Oella, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>10 YRS</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-29</u> 19 <u>58</u> to <u>6-14</u> 19 <u>61</u> , that I last saw the deceased alive on <u>6-12</u> 19 <u>61</u> , and that death occurred at <u>7:25 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>409 Columbia Road</u> DATE SIGNED <u>June 15, 1961</u>			
ACTUAL SIGNATURE <u>P. Thorpe</u> M.D.		PHYSICIAN'S NAME (Type) <u>Peter Van B. Thorpe, M.D.</u> <u>Ellicott City, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>6/19/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. HIGINBOTHOM</u> ADDRESS <u>Ellicott City, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 19 1961</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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6437

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06421

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Pidgeway Manor Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Agnes V. Callahan</i>		4. DATE OF DEATH <i>June 13/61</i> 19 <i>19</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 14, 1874</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W.</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>John Mock</i>		14. MOTHER'S MAIDEN NAME <i>Sarah</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Geo. T. Callahan</i> Address <i>4149 Mountwood Rd</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>334 x Apoplexy</i> DUE TO (b) <i>Arterio Sclerotic Cerebro</i> DUE TO (c) <i>Vascular Decort</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Seizure</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>June 13, 1961</i> to <i>June 13, 1961</i> , that (I) (we) last saw the deceased alive on <i>June 13, 1961</i> , and that death occurred at <i>2 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>M. Paul Byrley</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>M. Paul Byrley</i>		22d. ADDRESS <i>3033 W North A Balto</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>6/16/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	23d. LOCATION (City, town, or county) (State) <i>Prince Geo. Co. Md</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Walter F. N. 4101 Edmondson Ave.</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 16 '61</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6438

06422

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTO. CO.</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>X</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FREDERICK &amp; HILLSIDE RD.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>Frederick and Hillside Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>William S. CAMPBELL</u> First Middle Last <b>4. DATE OF DEATH</b> <u>June 5 19 61</u> Month Day Year		<b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>11/11/1882</u> Year Month Day	
<b>9. AGE</b> (In years last birthday) <u>78</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>machanist</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>electral</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Penna.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>James Campbell</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Digney</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>218-01-2477</u> <b>17. INFORMANT</b> <u>Mrs William Campbell</u> <u>Fred. &amp; Hillside Rds, Catonsville, 28, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>163X</u> DUE TO <u>Carcinoma Lung Rt.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Metastases to Liver.</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> <u>Drephrogastic Hernia</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State) <u>Mon 6/1 June 5 61</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>6/2/61</u> <b>19</b> to <u>June 5 61</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>6/2/61</u> , and that death occurred <u>at 4:00 PM</u> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>W.E. McGroth</u> M.D. <b>22b. DATE SIGNED</b> <u>6/5/61</u>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>1303 Frederick Rd Catonsville 28 Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u> <b>23b. DATE THEREOF</b> <u>6/8/61</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>New Cathedral</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, Md.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F.C. Haganbottom</u> <b>ADDRESS</b> <u>Ellicott City, Maryland</u> <b>25a. REC'D BY REGISTRAR</b> <u>JUN 9 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>	

33333

(M)

(I)

Notation for 7/1/68  
Correspondence from 1/1/68

Geophysical Horizon

1/1/68 - 1/1/68

8/1/68

1/1/68 - 1/1/68  
1/1/68 - 1/1/68  
1/1/68 - 1/1/68

1/1/68  
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1/1/68

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6439

06423

<b>1. PLACE OF DEATH</b> a. COUNTY Baltimore				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE Maryland			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ridgeway Manor-5743 Edmondson Avenue				e. STREET ADDRESS 5456 Frederick Road			
<b>3. NAME OF DECEASED</b> (Type or print) Grace Serio Cascio				<b>4. DATE OF DEATH</b> June 1, 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1895	
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Joseph Serio				14. MOTHER'S MAIDEN NAME Concetta Giglio			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mr. Vincent Cascio-6123 Northdale Road				Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.5em;">THROMBOSIS CEREBRAL</span> 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Hypertensive CV Disease. Diabetes Mellitus.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) 20a. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3-3-57</span> , 19 <span style="font-size: 1.2em;">57</span> , to <span style="font-size: 1.2em;">June 1</span> , 1961, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">May 31</span> , 1961, and that death occurred at <span style="font-size: 1.2em;">1015</span> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <span style="font-size: 1.5em;">John F. Schaefer</span>				22b. DATE SIGNED June 2 1961			
22c. PHYSICIAN'S NAME (Type) Dr. John F. Schaefer				22d. ADDRESS 101 Random Road			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-5-61		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <span style="font-size: 1.2em;">John F. Schaefer</span>				25a. REC'D BY REGISTRAR DATE JUN 2 '61			
25b. REGISTRAR'S SIGNATURE <span style="font-size: 1.2em;">Arthur L. Hume</span>				25c. ADDRESS 1017, Md			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
6440 06424											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>					
c. LENGTH OF STAY IN lb						d. STREET ADDRESS <b>104 E. Susquehanna Avenue</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>104 E. Susquehanna Avenue</b>						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ETHEL ELIZABETH CASLIN</b>						4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 21, 1911</b>		9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Clayton Lawson</b>						14. MOTHER'S MAIDEN NAME <b>Bessie Gouldman</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-10-3351</b>		17. INFORMANT <b>Family Records</b>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung with metastases</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>June 2, 1961</b> to <b>June 26, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 26, 1961</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>L. Myrton Gaines, Jr. M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>L. Myrton Gaines, Jr.</b>						22d. ADDRESS <b>714 York Road, Towson, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>June 28, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Gardens</b>		23d. LOCATION (City, town or county) <b>Timonium, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>						ADDRESS		25a. REC'D BY REGISTRAR <b>June 30 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles F. Howard</b>	



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L. Burton Gaines, Jr.

Part 1 June 28, 1961 Dulany Valley Gardens Thornton, Maryland

John Burns, Sons, Towson, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

6441

06425

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>33 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(23)</b> d. STREET ADDRESS <b>204 North Amity Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>WALTER</b>		<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>20</b> Year <b>1961</b>		<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>Negro</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>July 19, 1890</b>			
<b>9. AGE</b> (In years last birthday) <b>70</b> yrs. <b>10. KIND OF BUSINESS OR INDUSTRY</b> <b>Gas &amp; Electric Co.</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Anne Arundel Co., Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>		<b>13. FATHER'S NAME</b> <b>Walter Chase</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Galloway</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>16. SOCIAL SECURITY NO.</b> <b>212-05-3245</b> <b>17. INFORMANT</b> <b>Clinical Records, VAH, Baltimore 18, Maryland</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO <b>PERITONITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Due to SIGMOID PERFORATION</b> (c) <b>ARTERIOSCLEROTIC HEART DISEASE WITH FIBRILLATION</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 Days</b> <b>11 Days</b> <b>11 Days</b> <b>Unknown</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b>							
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 18</b> <b>4:30</b> to <b>June 20</b> , 1961, that (we) last saw the deceased alive on <b>June 20</b> , 1961, and that death occurred at <b>A.M.</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <i>Thomas F. Crahan</i> <b>M.D.</b>		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>22b. DATE SIGNED</b> <b>6/20/61</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>THOMAS F. CRAHAN, M.D.</b> <b>22d. ADDRESS</b> <b>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>23b. DATE THEREOF</b> <b>6/23/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National</b> <b>23d. LOCATION (City, town or county)</b> <b>Baltimore 28, Maryland</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Mrs. Katie R. Williams</i> <b>322 N. Schroeder Street</b> <b>Baltimore, Maryland</b> <b>25e. REC'D BY REGISTRAR</b> <b>JUN 22 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <i>Clara E. Kline</i>			

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Wm. H. Williams

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06426

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>_____</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House In The Pines</b>				d. STREET ADDRESS <b>2342 Edmondson Ave</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Florence Caroline Claus</b>				4. DATE OF DEATH Month Day Year <b>June 23, 1961</b>			
5. SEX <b>F.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 20, 1894</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stenographer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>_____</b>			
11. BIRTHPLACE (State or foreign country) <b>MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles W. Claus</b>				14. MOTHER'S MAIDEN NAME <b>Kathie M. Reese</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>_____</b>				16. SOCIAL SECURITY NO. <b>217-03-2471</b>			
17. INFORMANT Address <b>Mrs Robert Ernest, 6101 Brookwood Rd. #29</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Failure</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive - Cardio-vascular disease</b> DUE TO (c) <b>_____</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>_____</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1945</b> to <b>June 23, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 22, 1961</b> , and that death occurred at <b>20</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Homer U. Todd</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Homer U. Todd</b>				22d. ADDRESS <b>2108 St Paul St.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6/26/61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cmty.</b>				23d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D.</b>				25. REC'D BY REGISTRAR <b>JUN 26 '61</b>			
25a. ADDRESS <b>4101 Edmondson Ave.</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knead</b>			

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CHURCH OF DEATH

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Home in the House

Marriage Certificate

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6443  
CERTIFICATE OF DEATH  
06427

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>16 Cinder Road</b>				d. STREET ADDRESS <b>16 Cinder Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Elizabeth</b> Last <b>Coffman</b>				4. DATE OF DEATH Month <b>6-1-</b> Day <b>1961</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 23, 1904</b>	
9. AGE (In years lost birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>1</b> Hours <b>1</b> Min.		IF UNDER 24 HRS. Months <b>5</b> Days <b>1</b> Hours <b>1</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assembler</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bendix Corp. Virginia</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Franklin</b>				14. MOTHER'S MAIDEN NAME <b>Ocie Maupin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-10-9386</b>			
17. INFORMANT <b>Husband</b>				Address <b>16 Cinder Road Timonium Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL CARCINOMATOSIS - HEPATIC -</b> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>COLON CA -</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 MOS.</b> <b>5 YR.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <b>(U)</b> (this hospital) attended the deceased from <b>2-17-61</b> to <b>6-1-61</b> , that <b>(U)</b> (we) last saw the deceased alive on <b>5-31-1961</b> and that death occurred <b>8:00 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Donald O. Wood, MD</b>				22b. DATE SIGNED <b>6/2/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>DONALD O. WOOD, MD</b>				22d. ADDRESS <b>GREEN MEADOW RD 2 - TIMONIUM</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6-3-61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Memorial</b>				23d. LOCATION (City, town, or county) (State) <b>Finksburg Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service Towson 4, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 6 '61</b>			
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

CEEST

CERTIFICATE OF DEATH

133

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MAILED - ALL INFORMATION IN HEAD  
MAY BE OBTAINED FROM THE  
DEPARTMENT OF HEALTH  
AND HUMAN SERVICES  
WASHINGTON, D.C. 20495  
U.S. GOVERNMENT PRINTING OFFICE  
1975 O - 344-100

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Race: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Manner of death: [illegible]  
9. Signature of physician: [illegible]  
10. Signature of registrar: [illegible]  
11. Date of registration: [illegible]

1  
FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6644 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06428											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oella, Catonsville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>519 Oella Ave</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>—</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>45 Janney St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Henry J</u> Middle <u>Collins</u> Last <u>—</u>						4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-27-1882</u>		9. AGE (In years last birthday) <u>78</u> Yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>				11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Collins</u>						14. MOTHER'S MAIDEN NAME <u>? Flaherty</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)						16. SOCIAL SECURITY NO. <u>212 015 647</u>					
17. INFORMANT <u>Michael H. Collins</u>						Address <u>519 Oella Ave</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardio vascular disease</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>—</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <u>Geo. M. Kieffer</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>June 15.61</u> Address (Street, city, town, or county) <u>1010 Leeds Ave (29)</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-19-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore - Md</u>					
23. FUNERAL DIRECTOR <u>Max Nabb &amp; Son - Catonsville - 78 - Md</u>						24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			
DATE <u>JUN 20 '61</u>											

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CHIEF, K.M.

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06423

6445

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8604 SUMMIT Ave</u>		d. STREET ADDRESS <u>8604 SUMMIT Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>PATRIC K</u> First <u>J</u> Middle <u>D</u> Last <u>COOK</u>		4. DATE OF DEATH <u>JUNE</u> Month <u>10</u> Day <u>1961</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 21 - 1961</u>
9. AGE (In years lost birthday) yrs. <u>2</u> Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min.		10. IF UNDER 1 YEAR <u>2</u> Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PETER J COOK</u>		14. MOTHER'S MAIDEN NAME <u>JO ANN MYERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT <u>PETER J. COOK</u> Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> DUE TO <u>Pneumonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Bronchiolitis</u> (c) <u>acute</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>6/15</u> 19 <u>61</u> Hour o. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/15</u> , 19 <u>61</u> , to <u>6/10</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6/5</u> , 19 <u>61</u> , and that death occurred at <u>8:00</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasik, Jr.</u>		DATE SIGNED <u>6/10/61</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T KASIK JR.</u>		ADDRESS (Street, city or town, state) <u>9005 Harford Rd</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/12/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. F. EVANS &amp; SON</u>		ADDRESS <u>8802 Harford Rd</u>	
24a. REC'D BY REGISTRAR <u>JUN 13 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Evans</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06430

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7522 SCHOOL AVE.</u>				d. STREET ADDRESS <u>7522 SCHOOL AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>BERT</u> Middle <u>CRATER</u> Last				4. DATE OF DEATH Month <u>JUNE</u> Day <u>23</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-18-75</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>PERCIVAL CRATER</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA HONTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>170-05-598</u>		17. INFORMANT Address <u>HARRY CRATER, 7522 SCHOOL AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC C.V. DIS.</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>June 21, 1961</u> to <u>June 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 21, 1961</u> , and that death occurred at <u>1245</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Stephen C. Mackowian</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-23-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN C. MACKOWIAN</u>				22d. ADDRESS <u>6714 Hololand Ave Baltimore 12 Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>REMOVAL/BURIAL</u>				<u>GETHSEMANE CEM.</u>		<u>READING, PA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home, Dundalk, Md.</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE <u>JUN 27 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

05050

CERTIFICATE OF DEATH

237

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CHIEF

CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH e. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium					c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2303 Ravenview Road					d. STREET ADDRESS 2303 Ravenview Road									
3. NAME OF DECEASED (Type or print) Grace M. Crowther					4. DATE OF DEATH June 1, 1961									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 5, 1886		9. AGE (In years last birthday) 74 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME Charles Mackey					14. MOTHER'S MAIDEN NAME Martha ?									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no					16. SOCIAL SECURITY NO. no					17. INFORMANT Mr. C. M. Cummings-2303 Ravenview Road				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 170X DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma Rt. Breast (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes Mellitus										INTERVAL BETWEEN ONSET AND DEATH 10 mos. 10 mos.				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 6-22-61 to 6-1-61, that (I) (we) last saw the deceased alive on 6-1-61, and that death occurred at 11:30 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Robert H. Siver					22b. DATE SIGNED 6-2-61					22c. PHYSICIAN'S NAME (Type) Dr. Robert H. Siver				
22d. ADDRESS 3105 North Charles St. Balto. 18, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6-3-61		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery			23d. LOCATION (City, town or county) Woodlawn, Maryland						
24. FUNERAL DIRECTOR'S SIGNATURE John J. Siver					25a. REC'D BY REGISTRAR DATE JUN 2 '61					25b. REGISTRAR'S SIGNATURE Arthur S. Thomas				

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Government of Canada  
Minister of the Interior

Letter No. 1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6448

06432

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>22 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Sparks</b> d. STREET ADDRESS <b>Route 1, Box 30</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>LEVI</b> First <b>T.homas</b> Middle <b>CURTIS</b> Last		4. DATE OF DEATH <b>June</b> Month <b>18</b> Day <b>19 61</b> Year				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/1/94</b>	9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days <b>18</b> <b>19</b>	IF UNDER 24 HRS. Hours Min. <b>61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machine Tool Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Howard T. Curtis</b>		14. MOTHER'S MAIDEN NAME <b>Mary Frances Naylor</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>216-07-5701</b>		17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b> Address <b>Fort Howard Division</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMORRHAGE, RETROPERITONEAL MASSIVE</b> <b>451X</b> DUE TO <b>RUPTURE, (RECENT), ABDOMINAL AORTIC ANEURYSM</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS, MARKED, GENERALIZED</b> marked, bilateral. (c) <b>UNKNOWN</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>1. Portal Cirrhosis, liver, duration-unknown. 2. Pulmonary Emphysema, /</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>May 27</b> <b>1961</b> , to <b>June 18</b> <b>1961</b> that (2) (we) last saw the deceased alive on <b>June 18</b> <b>1961</b> , and that death occurred at <b>2:05</b> <b>P.</b> M. from the causes and on the date stated above.						
22a. SIGNATURE <b>Thomas F. Crahan</b> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/19/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. 18, MD, FORT HOWARD DIVISION</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-21-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Falls Road Methodist Church Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Sparks, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>XXXXX Brooks Funeral Home, 622 York Rd. Towson 4,</b> <b>Maryland</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JUN 20 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

Howard T. Goss



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06433

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bear Creek (Inverness)</u>		c. LENGTH OF STAY IN 1b <u>1 hr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wise Avenue, Bear Creek Bridge</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>FRANKLIN</u> Last <u>DAVIS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 FEB 1939</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brakeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pataps. Bk Rvr</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Davis</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Hood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u> <u>No</u>		16. SOCIAL SECURITY NO. <u>219-26-2792</u>	
17. INFORMANT <u>Mrs. Mamie B. Davis</u>		Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell into Bear Creek</u>	
20c. TIME OF INJURY Month, Day, Year <u>10</u> <u>pm.</u> <u>678 1961</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Wise Ave</u>		20f. (City or town) (County) (State) <u>Dundalk - in Baltimore Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M B Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Melvin B. Davis</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6/20/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-22-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN J. DUDA</u>		24a. REC'D BY REGISTRAR <u>7922 Wise avenue Baltimore 22, Md.</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>		DATE <u>JUN 26 '61</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06434

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>			c. LENGTH OF STAY IN TB <b>2 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1017 H Street</b>				d. STREET ADDRESS <b>1017 H Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>HENRY</b> Last <b>DENNIS</b>				4. DATE OF DEATH Month <b>June</b> Day <b>16th</b> Year <b>1961</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 27, 1874</b>		
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>16</b> Hours <b>16</b> Min.		IF UNDER 24 HRS. Months <b>8</b> Days <b>16</b> Hours <b>16</b> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Dennis</b>				14. MOTHER'S MAIDEN NAME <b>Mary Rice</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>213-07-9580</b>		17. INFORMANT <b>Mrs. John Stitz</b>		Address <b>same as #2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis - Heart Failure</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1, 1961</b> to <b>June 16, 1961</b> , that I last saw the deceased alive on <b>June 16, 1961</b> , and that death occurred at <b>5:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>520 D Street</b> DATE SIGNED <b>6/16/61</b>								
ACTUAL SIGNATURE <b>James T. Means</b>				PHYSICIAN'S NAME (Type) <b>James T. Means, M.D.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6/19/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>		
22d. LOCATION (City, town, or county) (State) <b>Dorsey, Maryland</b>								
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc.</b> ADDRESS <b>Dundalk 22, Md</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 21 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Means</b>		

MEDICAL CERTIFICATION

10034

# CERTIFICATE OF DEATH

1913

M

<p>1. Name of deceased: <b>William J. Smith</b></p>		<p>2. Age: <b>45</b></p>	
<p>3. Sex: <b>Male</b></p>		<p>4. Race: <b>White</b></p>	
<p>5. Date of death: <b>1913</b></p>		<p>6. Place of death: <b>Home</b></p>	
<p>7. Cause of death: <b>Heart Disease</b></p>		<p>8. Duration of illness: <b>2 weeks</b></p>	
<p>9. Name of physician: <b>Dr. J. H. Smith</b></p>		<p>10. Name of undertaker: <b>John Doe</b></p>	
<p>11. Name of funeral home: <b>None</b></p>		<p>12. Name of cemetery: <b>None</b></p>	
<p>13. Name of executor: <b>None</b></p>		<p>14. Name of administrator: <b>None</b></p>	
<p>15. Name of next of kin: <b>None</b></p>		<p>16. Name of informant: <b>None</b></p>	
<p>17. Name of registrar: <b>None</b></p>		<p>18. Name of registrar: <b>None</b></p>	
<p>19. Name of registrar: <b>None</b></p>		<p>20. Name of registrar: <b>None</b></p>	
<p>21. Name of registrar: <b>None</b></p>		<p>22. Name of registrar: <b>None</b></p>	
<p>23. Name of registrar: <b>None</b></p>		<p>24. Name of registrar: <b>None</b></p>	
<p>25. Name of registrar: <b>None</b></p>		<p>26. Name of registrar: <b>None</b></p>	
<p>27. Name of registrar: <b>None</b></p>		<p>28. Name of registrar: <b>None</b></p>	
<p>29. Name of registrar: <b>None</b></p>		<p>30. Name of registrar: <b>None</b></p>	
<p>31. Name of registrar: <b>None</b></p>		<p>32. Name of registrar: <b>None</b></p>	
<p>33. Name of registrar: <b>None</b></p>		<p>34. Name of registrar: <b>None</b></p>	
<p>35. Name of registrar: <b>None</b></p>		<p>36. Name of registrar: <b>None</b></p>	
<p>37. Name of registrar: <b>None</b></p>		<p>38. Name of registrar: <b>None</b></p>	
<p>39. Name of registrar: <b>None</b></p>		<p>40. Name of registrar: <b>None</b></p>	
<p>41. Name of registrar: <b>None</b></p>		<p>42. Name of registrar: <b>None</b></p>	
<p>43. Name of registrar: <b>None</b></p>		<p>44. Name of registrar: <b>None</b></p>	
<p>45. Name of registrar: <b>None</b></p>		<p>46. Name of registrar: <b>None</b></p>	
<p>47. Name of registrar: <b>None</b></p>		<p>48. Name of registrar: <b>None</b></p>	
<p>49. Name of registrar: <b>None</b></p>		<p>50. Name of registrar: <b>None</b></p>	
<p>51. Name of registrar: <b>None</b></p>		<p>52. Name of registrar: <b>None</b></p>	
<p>53. Name of registrar: <b>None</b></p>		<p>54. Name of registrar: <b>None</b></p>	
<p>55. Name of registrar: <b>None</b></p>		<p>56. Name of registrar: <b>None</b></p>	
<p>57. Name of registrar: <b>None</b></p>		<p>58. Name of registrar: <b>None</b></p>	
<p>59. Name of registrar: <b>None</b></p>		<p>60. Name of registrar: <b>None</b></p>	
<p>61. Name of registrar: <b>None</b></p>		<p>62. Name of registrar: <b>None</b></p>	
<p>63. Name of registrar: <b>None</b></p>		<p>64. Name of registrar: <b>None</b></p>	
<p>65. Name of registrar: <b>None</b></p>		<p>66. Name of registrar: <b>None</b></p>	
<p>67. Name of registrar: <b>None</b></p>		<p>68. Name of registrar: <b>None</b></p>	
<p>69. Name of registrar: <b>None</b></p>		<p>70. Name of registrar: <b>None</b></p>	
<p>71. Name of registrar: <b>None</b></p>		<p>72. Name of registrar: <b>None</b></p>	
<p>73. Name of registrar: <b>None</b></p>		<p>74. Name of registrar: <b>None</b></p>	
<p>75. Name of registrar: <b>None</b></p>		<p>76. Name of registrar: <b>None</b></p>	
<p>77. Name of registrar: <b>None</b></p>		<p>78. Name of registrar: <b>None</b></p>	
<p>79. Name of registrar: <b>None</b></p>		<p>80. Name of registrar: <b>None</b></p>	
<p>81. Name of registrar: <b>None</b></p>		<p>82. Name of registrar: <b>None</b></p>	
<p>83. Name of registrar: <b>None</b></p>		<p>84. Name of registrar: <b>None</b></p>	
<p>85. Name of registrar: <b>None</b></p>		<p>86. Name of registrar: <b>None</b></p>	
<p>87. Name of registrar: <b>None</b></p>		<p>88. Name of registrar: <b>None</b></p>	
<p>89. Name of registrar: <b>None</b></p>		<p>90. Name of registrar: <b>None</b></p>	
<p>91. Name of registrar: <b>None</b></p>		<p>92. Name of registrar: <b>None</b></p>	
<p>93. Name of registrar: <b>None</b></p>		<p>94. Name of registrar: <b>None</b></p>	
<p>95. Name of registrar: <b>None</b></p>		<p>96. Name of registrar: <b>None</b></p>	
<p>97. Name of registrar: <b>None</b></p>		<p>98. Name of registrar: <b>None</b></p>	
<p>99. Name of registrar: <b>None</b></p>		<p>100. Name of registrar: <b>None</b></p>	

10034

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
BALTO.		CATONSVILLE		CATONSVILLE		1605 ORPINGTON RD.	
13. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
JOHN A. DEPPISCH				6/4 1961			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		White				4/6/17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Sheet metal		Martin Co		Md		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
JOHN A. DEPPISCH		MARTHA DENN		Mrs Margaret Deppisch			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO				Sudden			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Hypertensive Cardio-vascular Disease				5 yrs.			
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
19				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (I) (the doctor) attended the deceased from June 1947 to June 1961, that (I) (we) saw the deceased alive on April 3, 1961, and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED			
Leo J. Gaver, M.D.				6/5/61			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
				1 Mallow Hill Ave., Baltimore 29, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
BURIAL		6/7/61		WOODLAWN		BALTO. CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR			
Margaret Deppisch				JUN 7 '61			
25b. REGISTRAR'S SIGNATURE							
				Arthur S. Thomas			

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151

(M)

(I)





may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

6452

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06436

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>				c. LENGTH OF STAY IN 1b <b>X BALTIMORE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1709 GLEN CURTIS RD.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>FREDERICK H. DIEFENBACH</b>				4. DATE OF DEATH Month Day Year <b>JUNE 1, 1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 4, 1904</b>		9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O RAILROAD</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN A. DIEFENBACH</b>				14. MOTHER'S MAIDEN NAME <b>MINNIE KREUZLER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mr. George Voelkel, 1709 Glen Curtis Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>199X</b> DUE TO <b>Unseen</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Renal shut down</b> (c) <b>metastatic carcinoma</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b> <b>2 days</b> <b>1 yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>1952 to 6/1</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>5/30 1961</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>J. Platt</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>J. PLATT, M.D.</b>		22d. ADDRESS <b>434 Eastern Ave Essex, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/5/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hartley Miller, 2334 Jefferson St.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 5 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thorne</b>	

10430

CERTIFICATE OF DEATH

10430

(M)

DECEASED  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
DISEASE  
AGE  
SEX  
MARRIAGE  
OCCUPATION  
EDUCATION  
RELIGION  
RACE  
COLOR  
HEIGHT  
WEIGHT  
HAIR  
EYES  
SKIN  
TENDRILS  
SCARS  
TATTOOS  
DENTAL  
FINGERPRINTS  
SIGNATURE  
TESTAMENTS  
WILLS  
PROPERTY  
EFFECTS  
CLOTHING  
JEWELRY  
PERSONAL EFFECTS  
MONEY  
BANK ACCOUNTS  
INSURANCE  
PENSIONS  
RENTS  
INCOME  
EXPENSES  
DEBTS  
CREDITS  
ASSETS  
LIABILITIES  
NET WORTH  
ESTATE  
SOURCES OF INCOME  
HISTORY OF ILLNESS  
PREVIOUS SURGERIES  
HOSPITAL ADMISSIONS  
PHYSICIAN'S REPORT  
LABORATORY TESTS  
X-RAYS  
AUTOPSY  
BURIAL  
CREMATION  
FUNERAL EXPENSES  
BURIAL PLACE  
CREMATION PLACE  
DATE OF BURIAL  
DATE OF CREMATION  
FUNERAL HOME  
COPIES OF CERTIFICATE  
FILING OFFICE  
FILING DATE  
FILING TIME  
FILING OFFICER  
FILING CLERK  
FILING NUMBER  
FILING INDEX  
FILING SEARCH  
FILING RECORD  
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FILING BOX  
FILING SHELF  
FILING DRAWER  
FILING CUPBOARD  
FILING CHEST  
FILING CLOSET  
FILING GARAGE  
FILING PORCH  
FILING PATIO  
FILING YARD  
FILING DRIVE  
FILING STREET  
FILING AVENUE  
FILING BOULEVARD  
FILING HIGHWAY  
FILING ROAD  
FILING LANE  
FILING COURT  
FILING PLACE  
FILING SQUARE  
FILING PLAZA  
FILING PARK  
FILING GARDEN  
FILING TERRACE  
FILING PORCH  
FILING PATIO  
FILING YARD  
FILING DRIVE  
FILING STREET  
FILING AVENUE  
FILING BOULEVARD  
FILING HIGHWAY  
FILING ROAD  
FILING LANE  
FILING COURT  
FILING PLACE  
FILING SQUARE  
FILING PLAZA  
FILING PARK  
FILING GARDEN  
FILING TERRACE

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6453 CERTIFICATE OF DEATH 06437

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>650 Orpington Rd.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>650 Orpington Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Martin H.</b> Middle <b>Dietrich</b> Last 5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Oct. 10/92</b> 9. AGE (In years lost birthday) <b>68</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1961</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Novak Realty Co.</b> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <b>Penna.</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Geo. Dietrich</b> 14. MOTHER'S MAIDEN NAME <b>Mary ----</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <input type="checkbox"/> 17. INFORMANT Address <b>Mrs. Margaret Dietrich, 650 Orpington Rd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Colon</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Months</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>6/28</b> 19 <b>60</b> to <b>6/30</b> 19 <b>61</b> , that (I) <del>was</del> last saw the deceased alive on <b>6/20</b> 19 <b>61</b> , and that death occurred on <b>6/30</b> 19 <b>61</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James Nolan</b> 22c. PHYSICIAN'S NAME (Type) <b>J. NOLAN</b>		22b. DATE SIGNED <b>7/1/61</b> 22d. ADDRESS <b>1 Mallow Hill Rd Balt 29</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>July 3/61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b> 23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 3 '61</b> 25b. REGISTRAR'S SIGNATURE <b>C. J. H. H. H.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D. 4101 Edmondson Ave.</b> ADDRESS			

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Ultimate

Operative

and Director

John B. Director

also

and Director

and Director

and Director

and Director

*Commissioner of Labor*

and Director

and Director

*John B. Director*

and Director

and Director

and Director

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **06438**

6454

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chattolance</i>		c. LENGTH OF STAY IN 1b <i>X Chattolance</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Charles Seymour Diggs</i>		4. DATE OF DEATH Month Day Year <i>June 17 1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 31, 1877</i>
9. AGE (In years last birthday) yrs. <i>84</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Doorman</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Boering, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Eli Diggs</i>		14. MOTHER'S MAIDEN NAME <i>Rachel Derricks</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <i>Mrs. Virginia White Diggins Mills, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>177X Carcinoma of prostate with metastases</i> DUE TO (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1955</i> to <i>17 June 1961</i> , that I last saw the deceased alive on <i>17 June 1961</i> , and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Paul H Royse</i> M.D. <i>1803 Foley Lane 19 June 61</i> PHYSICIAN'S NAME (Type) <i>PAUL H ROYSE</i> <i>Pikesville 08 Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/21/61</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Lukes Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Reisterstown, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph L. Russ</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 22 '61</i>	
24b. REGISTRAR'S SIGNATURE <i>Wm. S. Frank</i>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
6455					06439				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				
a. COUNTY Baltimore					a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville					b. COUNTY —				
c. LENGTH OF STAY IN lb 2mth ldy					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL					d. STREET ADDRESS 24 Whitfield Road				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) L. Alan					4. DATE OF DEATH June 21 19 61				
5. SEX male					6. COLOR OR RACE white				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH Aug. 8, 1885				
9. AGE (In years last birthday) 75 yrs.					10. IF UNDER 1 YEAR Months Days				
11. IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) banker					10b. KIND OF BUSINESS OR INDUSTRY Maryland				
11. BIRTHPLACE (County & State, or foreign country) U. S. A.					12. CITIZEN OF WHAT COUNTRY U. S. A.				
13. FATHER'S NAME Unknown Lewis Dill					14. MOTHER'S MAIDEN NAME Unknown Margaret Repp				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown					16. SOCIAL SECURITY NO. 215-01-9109				
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease									
422.1 DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis, severe									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
Benign prostatic hypertrophy									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <del>March 21</del> 1961, to June 21, 1961 that (I) (we) last saw the deceased alive on June 21, 1961, and that death occurred at 197:45 M, from the causes and on the date stated above.									
22a. SIGNATURE Stella Wachler M.D.									
22b. DATE SIGNED 6-21-61									
22c. PHYSICIAN'S NAME (Type) Stelb Wachler, M. D.									
22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
23b. DATE THEREOF 6-23-61									
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge									
23d. LOCATION (City, town or county) Pikesville Md.									
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto.									
25a. REC'D BY REGISTRAR JUN 26 '61									
25b. REGISTRAR'S SIGNATURE Arthur S. Hines									

MEDICAL CERTIFICATION

06438

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H. W. Jenkins & Sons Co., 1905 York Rd., Baltimore, Md.  
Baltimore, Md. 1905-06  
Baltimore, Md. 1905-06

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06440

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">6456</span> <span style="font-size: 1.2em;">Baltimore</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Towson</span> c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">5 mo.</span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <span style="font-size: 1.2em;">404 Far Hills Court</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Baltimore</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Towson</span> d. STREET ADDRESS <span style="font-size: 1.2em;">404 Far Hills Court</span> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="font-size: 1.2em;">Harriet Boynton Dodson</span>			<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">June</span> Day <span style="font-size: 1.2em;">11</span> Year <span style="font-size: 1.2em;">19 61</span>				
5. SEX <span style="font-size: 1.2em;">Female</span>		6. COLOR OR RACE <span style="font-size: 1.2em;">White</span>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <span style="font-size: 1.2em;">July 4, 1875</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">85</span> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife Home</span>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <span style="font-size: 1.2em;">New York</span>		
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">Samuel Boynton</span>				
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Harriet Purmort</span>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <span style="font-size: 1.2em;">No</span>				
16. SOCIAL SECURITY NO.			17. INFORMANT Address <span style="font-size: 1.2em;">Mrs. Norman Raymond Same</span>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">Acute pulmonary edema</span> <span style="font-size: 1.2em;">443 X</span> DUE TO <span style="font-size: 1.2em;">Arteriosclerosis, generalized</span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <span style="font-size: 1.2em;">Congestive heart failure</span> DUE TO <span style="font-size: 1.2em;">Hypertension</span> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <span style="font-size: 1.2em;">19</span>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1950</span> to <span style="font-size: 1.2em;">June 1961</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">7 June 1961</span> , and that death occurred at <span style="font-size: 1.2em;">4:30 P.M.</span> from the causes and on the date stated above.							
22a. SIGNATURE <span style="font-size: 1.2em;">Dr. Louis Hamburger</span> M.D.				22b. DATE SIGNED <span style="font-size: 1.2em;">June 12 1961</span>			
22c. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Dr. Louis Hamburger</span>				22d. ADDRESS <span style="font-size: 1.2em;">1001 St. Paul Street</span>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		23b. DATE THEREOF <span style="font-size: 1.2em;">June 13, 1961</span>		23c. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Green Mount</span>			
23d. LOCATION (City, town or county) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <span style="font-size: 1.2em;">John O. Mitchell &amp; Sons, Inc. 1900 Eutaw Place</span>				25a. REC'D BY REGISTRAR DATE <span style="font-size: 1.2em;">JUN 14 '61</span>			
25b. REGISTRAR'S SIGNATURE <span style="font-size: 1.2em;">Arthur S. Harris</span>				25c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(1)

JOHN C. WILSON & SONS, INC. 1000 E. 10th St. S.W. ALBUQUERQUE, N.M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1  
6457  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
06441

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxonhill, Maryland</b>	
c. LENGTH OF STAY IN 1b <b>2 days</b>		d. STREET ADDRESS <b>4406 Brockton Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Sue</b> Middle <b>Dorset</b> Last <b>Dorset</b>		<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>21</b> Year <b>19 61</b>	
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>April 9, 1875</b>
<b>9. AGE</b> (In years last birthday) <b>86 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>86</b> Days <b>86</b>	<b>11. IF UNDER 24 HRS.</b> Hours <b>86</b> Min. <b>86</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Virginia</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>U. S. A.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>unknown</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>unknown</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>unknown</b> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>unknown</b>	
<b>17. INFORMANT</b> <b>RECORDS: Spring Grove State Hospital</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from June 19, 1961 to June 21, 1961, that (I) (we) last saw the deceased alive on June 21, 1961, and that death occurred at 9:05 P.M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Stella Wachsler</b> M.D.		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>6-22-61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Stella Wachsler, M. D.</b>		<b>22d. ADDRESS</b> <b>SPRING GROVE STATE HOSPITAL</b> <b>Catonsville 28, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Buried 6-24-61</b>		<b>23b. DATE THEREOF</b> <b>6-24-61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Cmt.</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Switzland Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Lee Turner Home Wash. D.C.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JUN 26 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hume</b>		<b>25c. DATE</b> <b>JUN 26 '61</b>	

1945

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See also Volume 10  
of the series  
1945



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Page 4

1  
6458  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06442

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN 1b <b>XBALTIMORE 22</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>14000 NORTH POINT ROAD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>JOHN</b> Last <b>DUNBAR</b>		4. DATE OF DEATH Month <b>6</b> - Day <b>19</b> - Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-17-'98</b>
9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAITER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>	
11. BIRTHPLACE (State or foreign country) <b>SCOTLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>GEORGE DUNBAR</b>		14. MOTHER'S MAIDEN NAME <b>HELEN GOULDIE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF ESOPHAGUS</b> <b>150X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002X FAR ADVANCED PULMONARY TUBERCULOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-5-1960</b> to <b>6-19-1961</b> , that (I) (we) last saw the deceased alive on <b>6-15-1961</b> , and that death occurred at <b>12:51 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Wm. Newcomer</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D. Superintendent</b>		22d. ADDRESS <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>	
23a. BURIAL, CREMATION, (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-21-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		25a. REC'D BY REGISTRAR <b>JUN 21 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Cecilus S. Kraus</b>			

CERTIFICATE OF DEATH

(M)

JOHN

ARTHUR

HELEN ROSE

(1)

DATE OF DEATH 1915

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **06443**

6459

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE - 19 MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>AN</b> b. COUNTY <b>AN</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SPARROWS POINT</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1241 BEECH WOOD RD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MICHAEL EUGENE DUNCAN</b>		4. DATE OF DEATH <b>JUNE 3, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 12/61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DAVID THEODORE DUNCAN</b>		14. MOTHER'S MAIDEN NAME <b>BETTY MAE PERSINGER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>FATHER</b>		Address <b>ASIN #1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE BRONCHO PNEUMONIA</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>491X</b> DUE TO (c) <b>491X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UNDERWEIGHT AT BIRTH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 2, 1961</b> to <b>June 3, 1961</b> , that I last saw the deceased alive on <b>June 2, 1961</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Louis N. Tollin</b>		ADDRESS (Street, city or town, state) <b>6908 N. Pt. Rd.</b>	
PHYSICIAN'S NAME (Type) <b>LOUIS N. TOLLIN</b>		DATE SIGNED <b>6/3/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/5/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BelAir Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>BelAir, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk 22, Md</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 6 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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Form with multiple lines for text entry, including fields for name, date, and location. The text is mirrored and difficult to read.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

6460

06444

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1102 Frederick Ave</b>		d. STREET ADDRESS <b>1102 Frederick Ave</b>	
3. NAME OF DECEASED (Type or print) <b>Willie M. Early</b>		4. DATE OF DEATH <b>June 21 1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 18 1866</b>
9. AGE (In years last birthday) <b>95 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Amorn Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Cooper</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Address</b>	
17. INFORMATION		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Decompensation</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Generalized arteriosclerosis</b> (a), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <b>14k.</b> <b>15yr.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/16/1943</b> to <b>6-21-1961</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>6-20-1961</b> , and that death occurred <b>21-6-1961</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Wilmer K. Gallagher</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b>		22d. ADDRESS <b>6209 Frederick Rd, Baltimore-28, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremated</b>		23b. DATE THEREOF <b>6-23-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wayensboro Va</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harley Caranough Jr FH</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 26 '61</b>	
ADDRESS <b>Catonsville</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Hanna</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
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VR A15 (4)  
15M 9/59

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6461  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06445

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1227 Francis Avenue</b>		d. STREET ADDRESS <b>1227 Francis Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Herbert Eckart</b>		4. DATE OF DEATH Month Day Year <b>June 1, 1961 19</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 19, 1907</b>
9. AGE (In years lost birthday) <b>54 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ornamental Iron Mfg.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Andrew Eckart</b>		14. MOTHER'S MAIDEN NAME <b>Jane Grace</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-09-7807</b>	
17. INFORMANT <b>Rose H. Eckart</b>		Address <b>1227 Francis Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 mo</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 15, 1961</b> to <b>June 1, 1961</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>June 1, 1961</b> , and that death occurred at <b>9:15 P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>A. Bradley Daugharthy</b> M.D.		22b. DATE SIGNED <b>June 1, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. Bradley Daugharthy, M. D.</b>		22d. ADDRESS <b>1264 Francis Avenue; Balto. 27, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/5/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Elrkidge, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		25a. REC'D BY REGISTRAR <b>JUN 5 '61</b>	
ADDRESS <b>4107 Wilkens Ave.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



Howard N. Hubbard 4107 Wilkins Ave.

Need White Cemetery, Hixson, Maryland

1931 (approx) (approx) (approx)

1931 (approx) (approx) (approx)

1931 (approx) (approx) (approx)

1931 (approx) (approx) (approx)

Andrew Eckert

Baltimore, Maryland

Feb. 10, 1931

June 1, 1931

1931 (approx) (approx) (approx)

Baltimore

Baltimore

Baltimore

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 06446

6462

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Reisterstown</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11419 Reisterstown Road</u>		d. STREET ADDRESS <u>11419 Reisterstown Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>CARRIE A. ECKENRODE</u>		4. DATE OF DEATH <u>June 29 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 2, 1878</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Westminster</u>	9c. AGE (In years last birthday) <u>83</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Westminster</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Mary ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr Chas. H. DeVos</u>		Address <u>Some address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - generalized</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September, 1957</u> , to <u>June 29, 1961</u> , that I last saw the deceased alive on <u>June 29, 1961</u> , and that death occurred at <u>5:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clarence E. Williams</u>		ADDRESS (Street, city or town, state) <u>11904 Reisterstown Rd., Reisterstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>—</u>		DATE SIGNED <u>June 29, 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/1/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Westminster, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u>	24b. REGISTRAR'S SIGNATURE <u>Clarence S. Kline</u>
DATE <u>July 3 '61</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF CLERGYMAN		19. SIGNATURE OF JUDGE		20. SIGNATURE OF JURY	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF CLERGYMAN		24. SIGNATURE OF JUDGE		25. SIGNATURE OF JURY	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF NEXT OF KIN		28. SIGNATURE OF CLERGYMAN		29. SIGNATURE OF JUDGE		30. SIGNATURE OF JURY	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF NEXT OF KIN		33. SIGNATURE OF CLERGYMAN		34. SIGNATURE OF JUDGE		35. SIGNATURE OF JURY	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF NEXT OF KIN		38. SIGNATURE OF CLERGYMAN		39. SIGNATURE OF JUDGE		40. SIGNATURE OF JURY	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF CLERGYMAN		44. SIGNATURE OF JUDGE		45. SIGNATURE OF JURY	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF NEXT OF KIN		48. SIGNATURE OF CLERGYMAN		49. SIGNATURE OF JUDGE		50. SIGNATURE OF JURY	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF NEXT OF KIN		53. SIGNATURE OF CLERGYMAN		54. SIGNATURE OF JUDGE		55. SIGNATURE OF JURY	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF NEXT OF KIN		58. SIGNATURE OF CLERGYMAN		59. SIGNATURE OF JUDGE		60. SIGNATURE OF JURY	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF NEXT OF KIN		63. SIGNATURE OF CLERGYMAN		64. SIGNATURE OF JUDGE		65. SIGNATURE OF JURY	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF NEXT OF KIN		68. SIGNATURE OF CLERGYMAN		69. SIGNATURE OF JUDGE		70. SIGNATURE OF JURY	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF NEXT OF KIN		73. SIGNATURE OF CLERGYMAN		74. SIGNATURE OF JUDGE		75. SIGNATURE OF JURY	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF NEXT OF KIN		78. SIGNATURE OF CLERGYMAN		79. SIGNATURE OF JUDGE		80. SIGNATURE OF JURY	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF CLERGYMAN		84. SIGNATURE OF JUDGE		85. SIGNATURE OF JURY	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF NEXT OF KIN		88. SIGNATURE OF CLERGYMAN		89. SIGNATURE OF JUDGE		90. SIGNATURE OF JURY	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF NEXT OF KIN		93. SIGNATURE OF CLERGYMAN		94. SIGNATURE OF JUDGE		95. SIGNATURE OF JURY	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF NEXT OF KIN		98. SIGNATURE OF CLERGYMAN		99. SIGNATURE OF JUDGE		100. SIGNATURE OF JURY	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **06447**

6463

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House In The Pines Nursing Home</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b> d. STREET ADDRESS <b>02 X-2 Mountain Road, Jacobsville</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Gustavo</b> Middle <b>W.</b> Last <b>Ehrecke, Jr.</b>				4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>28<sup>th</sup> Nov. 1880</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>24</b> Hours <b>10</b> Min.		IF UNDER 24 HRS. Hours <b>10</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elec. Eng. (ret.)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Kansas City Pub. Serv.</b>		11. BIRTHPLACE (State or foreign country) <b>Wausau, Wisconsin</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Richard Ehrecke</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Giesler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>486-075-448A</b>		17. INFORMANT <b>G. Wm. Ehrecke, Jr.</b> Address <b>Same As #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>10 yrs.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile dementia with Cortical atrophy</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat white <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>6/17/1961</b> , to <b>6/20/1961</b> , that I last saw the deceased alive on <b>6/20/1961</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6209 Frederick Ave.</b> DATE SIGNED <b>6/20/61</b>							
ACTUAL SIGNATURE <b>Wilmer K. Gallagher</b>				M.D. <b>6209 Frederick Ave.</b>			
PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b>				<b>Baltimore, 28, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>23<sup>rd</sup> June '61</b>		<b>Chatham Center Rural Cem.</b>		<b>Chatham, N.Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. V. Suptela</b> ADDRESS <b>Glen Burnie, Md.</b>				24a. REC'D BY REGISTRAR <b>JUN 26 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 15, 1900</u></p>	
<p>5. Place of birth: <u>Johns Hopkins</u></p>		<p>6. Date of death: <u>Dec 10, 1945</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of filing: <u>Dec 15, 1945</u></p>		<p>12. File number: <u>12345</u></p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
06448											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold				c. LENGTH OF STAY IN 1b X Arnold				b. COUNTY Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route # 3 Box 273				d. STREET ADDRESS 1 Route # 3 Box 273				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last VERNON LOUIS ELY				4. DATE OF DEATH Month Day Year June 1, 1961 19							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 11, 1905		9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance				10b. KIND OF BUSINESS OR INDUSTRY Amoco Company				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John C. Ely				14. MOTHER'S MAIDEN NAME Grace ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 216-18-7468				17. INFORMANT Mrs. Vernon L. Ely-Route # 3 Box 273-Arnold Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 414X } DUE TO Conditions, any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Subacute Bacterial Endocarditis (c) Rheumatic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 2-15-61, to 5-31-61, that (I) (we) last saw the deceased alive on 5-31-1961, and that death occurred at M, from the causes and on the date stated above. 22a. SIGNATURE Frank M. Shipley M.D. 22b. DATE SIGNED 5-1-61 22c. PHYSICIAN'S NAME (Type) FRANK M. SHIPLEY 22d. ADDRESS Annapolis, Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 6-3-61 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery 23d. LOCATION (City, town or county) (State) Woodlawn, Maryland 24. FUNERAL DIRECTOR'S SIGNATURE North Anna Ave Baltimore, Md. 25a. REC'D BY REGISTRAR JUN 2 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas											

84330



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06449

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7 Admiral Blvd.</b>		d. STREET ADDRESS <b>7 Admiral Blvd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>JANE</b> Last <b>EVANS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 9, 1889</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wales</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Rees</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Davies</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>Dr. Eugene Evans 1 Liberty Pkwy-22</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Hypertensive Cardio-Vascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 11, 1961</b> to <b>June 13, 1961</b> , that I last saw the deceased alive on <b>June 11, 1961</b> , and that death occurred at <b>2:10 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Lester Lebo</b>		ADDRESS (Street, city or town, state) <b>1801 Enoch Pl. Balt 17, Md.</b>	
PHYSICIAN'S NAME (Type) <b>LESTER LEBOWITZ</b>		DATE SIGNED <b>6/14/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 16, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colgate, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ulrich Funeral Home Dundalk, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 16 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

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UNITED STATES OF AMERICA

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Department

of the Interior

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6466

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06450

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		c. LENGTH OF STAY IN 1b <b>28 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>708 "E" Street</b>				d. STREET ADDRESS <b>708 "E" Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>W. L. Ford</b> Middle <b>Bateman</b> Last <b>FAIRBANK</b>				4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 7, 1901</b>	
9. AGE (In years last birthday) <b>59 yrs.</b>		IF UNDER 1 YEAR Months <b>59</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Mill</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>J. Frank Fairbank</b>				14. MOTHER'S MAIDEN NAME <b>Annie White</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213 01 8966</b>		17. INFORMANT Address <b>J. Harry Fairbank, Tilghman, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CA of Lower bowel</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>0</b> p. m. <b>0</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Jack C Collins</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JACK C Collins</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/6/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fairbank Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Fairbank, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Hamilton</b>				ADDRESS <b>St. Michaels, Md</b>		24a. REC'D BY REGISTRAR <b>JUN 8 '61</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>	





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

6467

06451

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>			c. LENGTH OF STAY IN 1b <b>X</b> <b>Lutherville</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1518 Riderwood- Lutherville Dr.</b>				d. STREET ADDRESS <b>1518 Riderwood-Luth. Dr.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harry Eugene Fendlay</b>		First Middle Last		4. DATE OF DEATH Month <b>6</b> Day <b>14</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-11-1875</b>		9. AGE (In years lost birthday) yrs. <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penn. Rail Road</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James B. Febdlay</b>				14. MOTHER'S MAIDEN NAME <b>Mary Dorerr</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>?????</b>		17. INFORMANT Address <b>Harry F. Fendlay 1518 Luth- Riderwood Dr.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>bronchial pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic cerebrovascular disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1956</b> to <b>6/14</b> , 1961, that (I) (we) last saw the deceased alive on <b>6/14 1961</b> , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Charles F. O'Donnell</i> M.D.				22b. ADDRESS <b>7501 York Rd Towson 4 Md</b>		22c. DATE SIGNED <b>6/15/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell</b>				22d. ADDRESS <b>7501 York Rd Towson 4 Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-17-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Josephs Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Texas, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service Towson 4, Maryland</b>				25a. REC'D BY REGISTRAR <b>JUN 20 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

M

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MEDICAL CERTIFICATION

ok  
C.F.O.  
Medical Examiner



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06452

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>5 yr</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., 21 Leeway, Dundalk 22, Md.</b>				d. STREET ADDRESS <b>21 Leeway, Dundalk 22, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Adeline</b> <b>Finn</b>				4. DATE OF DEATH <b>June 10, 1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 28, 1894</b>		9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tomato Pckg.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ceffalo Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Roberto</b>				14. MOTHER'S MAIDEN NAME <b>Emily Bassett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-10-3142</b>		17. INFORMANT <b>Mrs. Catherine Falkenhan</b> Address <b>21 Leeway 22</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Myocardial infarct</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>6 yrs</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 men</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Sack Collins</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6-10-61</b>	
EXAMINER'S NAME (Type) <b>Sack Collins</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 14, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>4300 Old Frederick Rd. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN J. DUDA</b> ADDRESS <b>7922 Wise Ave. 22, Md.</b>				24a. REC'D BY REGISTRAR <b>JUN 13 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6469

06453

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>3 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore (7)</b> d. STREET ADDRESS <b>5512 Hutton Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>VERNON L. FINNEGAN</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>19 61</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 23, 1890</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Installation Co.</b>		11. BIRTHPLACE (Country & State, or foreign country) <b>Pikesville, Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Thomas Finnegan</b>			14. MOTHER'S MAIDEN NAME <b>Catherine White</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>212-07-1150</b>		17. INFORMANT Address <b>Clinical Records, VA Hospital, Baltimore 18, Maryland, Fort Howard Division</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>CARCINOMA OF BLADDER</b> DUE TO (c) <b>1810</b>					INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>3 YEARS</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Operation 1958, Fulguration of bladder tumor							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 20, 1961</b> to <b>June 23, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 23, 1961</b> , and that death occurred at <b>5:20 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Thomas F. Crahan</i> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/23/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN</b>		22d. ADDRESS <b>M.D. VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>JUNE 25 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore Co., Maryland</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>G. Truman Schwab</b>		ADDRESS <b>3512 Frederick Ave. Balto. Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 26 '61</b>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Yves Howard

3 days

Baltimore (1)

2211 Madison Avenue

Yves Howard Hotel

VERMONT

WINDSOR

June

March 22, 1964

White

Male

Investigation Co. Minneapolis, Minnesota

Corporate

Executive Office

Thomas E. Howard

(I)

W.I.

INS

CONFIDENTIAL

MEMORANDUM FOR MR. TOLSON

RE: YVES

Question 1: Information of Police Dept.

Page 50

Page 51

*[Handwritten signature]*

THOMAS E. HOWARD

W.D. WASHINGTON, D.C.

RECEIVED

Investigation Co.

Minneapolis, Minnesota

O. Thomas Howard, 2211 Madison Avenue, Minneapolis, Minnesota



## CERTIFICATE OF DEATH

Reg. Dist. No. 06454

6470

1. PLACE OF DEATH a. COUNTY <u>Catonsville Balto Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>5200 BA Blvd</u> COUNTY <u>GA Co Md</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Freetown Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Charles</u> Last <u>Fischer</u>		4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 28 - 1882</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Fischer</u>		14. MOTHER'S MAIDEN NAME <u>Frances Reahe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-32-8025</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), or (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 29, 1961</u> to <u>June 11, 1961</u> , that I last saw the deceased alive on <u>June 9, 1961</u> and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bahram Sina</u>		DATE SIGNED <u>June 13-61</u>	
PHYSICIAN'S NAME (Type) <u>BAHRAM SINA M.D.</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 14-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Catholic Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Belmad G. Fink</u>		24a. REC'D BY REGISTRAR <u>Blaykome Md</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Klaus</u>		DATE <u>JUN 15 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06455

6471

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b>		c. LENGTH OF STAY IN lb <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Ruxton</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1714 Ruxton Rd.</b>				d. STREET ADDRESS <b>1714 Ruxton Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Fisher</b> Last <b>Fisher</b>				4. DATE OF DEATH Month <b>6</b> Day <b>17</b> Year <b>1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-31-1880</b>		9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>17</b>	IF UNDER 24 HRS. Hours <b>17</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Broker</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Frank Fisher</b>			14. MOTHER'S MAIDEN NAME <b>Frances Virginia Poor</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mrs. Nannie H. Fisher</b>		Address <b>Above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Pneumonia (Lobar) Pulmonary oedema</b> DUE TO (b) <b>433.1 Ateriorsclerotic heart disease with auricular fibrillation</b> DUE TO (c) <b>Severe generalized arteriorsclerosis, cerebral arteriorsclerosis, gangrene both feet (arteriorsclerotic)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>15 years</b> <b>3 weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>a.m.</b> <b>19</b> p.m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1950</b> , 19....., to <b>death</b> , 19..61 that (I) (we) last saw the deceased alive on <b>4 P.M.</b> 19.61, and that death occurred <b>4:45 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>B. H. Rutledge, M.D.</b>			ATTENDING PHYS. <input type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6/19/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>B. H. Rutledge, M.D.</b>			22d. ADDRESS <b>18 E. Eager Street</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6-19-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION (City, town or county) <b>Balto.</b>		(State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b>			ADDRESS <b>4905 York Rd.</b>		25a. REC'D BY REGISTRAR <b>JUN 20 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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Mrs. William H. Fisher

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H. W. Jenkins - 1802 York Rd. Baltimore, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6472

06456

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>104 S. Withwood Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Summit Home</u>				d. STREET ADDRESS <u>Catonsville 28</u>			
3. NAME OF DECEASED (Type or print) <u>JOSEPH C. FLORA</u>				4. DATE OF DEATH Month <u>6</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/29/74</u>	9. AGE (In years and birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ret.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Fred Flora</u>				14. MOTHER'S MAIDEN NAME <u>Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Smith</u> Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute &amp; chronic congestive Heart Failure</u> DUE TO (b) <u>Degenerative Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/8/61</u> to <u>6/8/61</u> , that (I) <u>  </u> saw the deceased alive on <u>6/8/61</u> , and that death occurred <u>2:45 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W.E. McGrath</u> M.D.				22b. DATE SIGNED <u>6/9/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>W.E. McGrath</u>				22d. ADDRESS <u>1303 Frederick Rd Catonsville 28 md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/12/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Louis</u>		23d. LOCATION (City, town or county) (State) <u>Howard Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>McGrath &amp; Son</u> ADDRESS <u>28</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 14 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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General's Address  
Department of State  
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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 6473 CERTIFICATE OF DEATH 06457

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Butler</b>				c. LENGTH OF STAY IN 1b <b>11fe</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Falls Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM ARTHUR FOWBLE, SR.</b> First Middle Last				4. DATE OF DEATH <b>6-2-61</b> Month Day Year			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-31-1894</b>	9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>self empl. sales</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>real estate</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lewis M. Fowble</b>				14. MOTHER'S MAIDEN NAME <b>Susie Frank</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>215-05-1697</b>		17. INFORMANT Address <b>Grace A. Fowble, Butler, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of abdominal</b> DUE TO <b>recurrent</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cachexia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>8 month</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4-10-60</b> to <b>6-2-61</b> , that (I) (we) last saw the deceased alive on <b>5-17-61</b> and that death occurred at <b>4 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>James G. Saffell</b>				22b. DATE SIGNED <b>6-5-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>James G. Saffell</b>				22d. ADDRESS <b>Keisters town, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-5-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Black Rock</b>		23d. LOCATION (City, town, or county) (State) <b>Butler, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson4, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6474

06458

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>25 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		e. STREET ADDRESS <u>248 S. Duncan Street - 31</u>	
3. NAME OF DECEASED (Type or print) <u>CHRISTOPHER J. FRIEL</u>		4. DATE OF DEATH <u>June 3 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1897</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR <u>3</u> Months <u>19</u> Days <u>61</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW-1</u>		16. SOCIAL SECURITY NO. <u>WW-1</u>	
17. INFORMANT <u>Clinical Records, VAH 3900 Loch Raven Boulevard, Balto 18, Md. FORT HOWARD DIVISION</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EPIDERMOID CARCINOMA, LEFT PHARYNX</u> DUE TO (b) <u>148X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>148X</u> DUE TO (c) <u>148X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 9</u> to <u>June 3</u> , 1961, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>June 3</u> , 1961, and that death occurred at <u>10:50 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Norman P. Jones</u> M.D.		22b. DATE SIGNED <u>6/3/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>NORMAN P. JONES, M.D.</u>		22d. ADDRESS <u>VAH Fort Howard, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-7-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc. Baltimore, Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 7 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6475

## CERTIFICATE OF DEATH

06459

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		
c. LENGTH OF STAY IN 1b			d. STREET ADDRESS <b>458 Main Street</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>458 Main Street</b>			a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>R.</b> Last <b>Fuss</b>			4. DATE OF DEATH Month <b>June</b> Day <b>8,</b> Year <b>19 61</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Feb. 28, 1894</b>		9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b>	
IF UNDER 24 HRS. Hours <b>1</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Builder</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Albert Fuss</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Woods</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WWL</b>		16. SOCIAL SECURITY NO. <b>215-01-4688 A</b>	
17. INFORMANT <b>Mrs. Edith E. Fuss Reisterstown, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive C-V Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour <b>none</b> e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	
20f. (City or town) <b>none</b>		20g. (County) <b>none</b>		20h. (State) <b>none</b>	
21. I certify that (I) ( <del>he</del> ) attended the deceased from <b>6-12-45</b> , 19 <b>45</b> , to <b>6-8-61</b> , 19 <b>61</b> , that (I) ( <del>she</del> ) last saw the deceased alive on <b>5-11-61</b> , 19 <b>61</b> , and that death occurred at <b>1:30P</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>A. D. Caples</b>		M.D.		22b. DATE SIGNED <b>6-9-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>		22d. ADDRESS <b>6 Hanover Rd., Reisterstown, Maryland</b>		22e. REC'D BY REGISTRAR <b>DATE JUN 12 '61</b>	
22f. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 10, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City, town or county) <b>Pikesville</b>		(State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons</b>		ADDRESS <b>Reisterstown, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 12 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. REC'D BY REGISTRAR <b>DATE JUN 12 '61</b>		25d. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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Representative G-V Placans

5-11-51

W. D. Gables, Jr. D.

John F. Kennedy

W. F. Blinn



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06460**

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Oak Grove Apts - 11 Maple Ave</b>		d. STREET ADDRESS <b>5521 Ritter Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>George</b>		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>19 61</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 23, 1901</b>
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>1</b> Hours <b>4</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Apt. Bldg</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John L. George</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Hare</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-09-6600</b>	
17. INFORMANT <b>Mrs. Maudie P. George</b>		Address <b>5521 Ritter Avenue</b> Zone <b>6</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>42201</b> DUE TO <b>A-S-C-V Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Trauma</b>	
20c. TIME OF INJURY Month, Day, Year <b>19 61</b> Hour <b>19</b> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M.B. Davis</b>		DATE SIGNED <b>6/29/61</b>	
EXAMINER'S NAME (Type) <b>M.B. DAVIS M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6-30-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Elkridge, Md. R.F.D.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Towson, Inc., 1050 York Road, Towson</b>		24a. REC'D BY REGISTRAR <b>JUL 3 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DOE STATE  
HEALTH DEPT.

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WARTLAND STATE DEPARTMENT OF HEALTH - BALTHIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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Name of Deceased		John L. Doe	
Sex		Male	
Race		White	
Date of Birth		Jan. 1, 1911	
Place of Birth		Baltimore, Maryland	
Residence		Baltimore, Maryland	
Occupation		None	
Cause of Death		Heart Disease	
Date of Death		Jan. 1, 1911	
Place of Death		Baltimore, Maryland	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	

William S. Howard

VR A15 (4)  
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Fred Mack

Florence Phelps

Edward M. Gatz

121-01-332 Kate Gatz 238 121-01-332

Prospect Hill Glenview, Ill.

Mr. Robinson Glenview, Ill.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06462

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>J</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>3 1/2 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		d. STREET ADDRESS <b>4303 ST. THOMAS AVE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>GIBBS</b> Last <b>GIBBS</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-8-1868</b>
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>AUGUST HAINZE</b>		14. MOTHER'S MAIDEN NAME <b>MARIE SHER.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Frank R. Smith Jr.</b> Address <b>Cockeysville Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> 422.1 DUE TO <b>Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b></b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-4</b> 19 <b>57</b> , to <b>6-2</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>5-31</b> 19 <b>61</b> , and that death occurred at <b>8:05 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter T. Kees</b>		22b. DATE SIGNED <b>6/2/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>		22d. ADDRESS <b>COCKEYSVILLE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-5-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Schwartz's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		25a. REC'D BY REGISTRAR <b>JUN 5 '61</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

hours after death. Page 4

by the funeral director,  
should be filed with

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## CERTIFICATE OF DEATH

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06463

that the death certificate be executed

VR A15 (4)  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6480

## CERTIFICATE OF DEATH

Reg. Dist. No. 06464

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				c. LENGTH OF STAY IN 1b <b>5 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Res., 300 Pinewood Rd. 22, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Charles</b> <b>Edward</b> <b>Gray</b> <b>Lost</b>				4. DATE OF DEATH <b>June</b> <b>4</b> , Day <b>61</b> , Year <b>19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1906</b>		9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR: Months <b>3</b> Days <b>5</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crane operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Patapsco Scrap Corp</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas E. Gray</b>				14. MOTHER'S MAIDEN NAME <b>Barbara E. Dolan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>163-14-2393</b>		17. INFORMANT <b>Mrs. Pauline Gray</b> Address <b>300 Pinewood Rd. 22, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Calcinoses</b> DUE TO (c) <b>LUNG cancer w/ gan. metastasis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>Nov 1956</b> to <b>June 1961</b> , that I last saw the deceased alive on <b>June 4, 1961</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles B. Berris</b> M.D.				ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>June 6-1961</b>			
PHYSICIAN'S NAME (Type) <b>Oswald Berris MD</b>				2903 West Woodwell Rd			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-7-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		22d. LOCATION (City, town, or county) (State) <b>Taylor Ave. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN J. DUDA</b> ADDRESS <b>7922 Wise Ave. 22, Md.</b>				24a. REC'D BY REGISTRAR <b>JUN 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thane</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6481

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06465

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kenwood.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kenwood.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>19 McCormick Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Deborah</u> Middle <u>Ann</u> Last <u>Greely</u>				4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1961</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 26 1954</u>	
9. AGE (In years last birthday) <u>7</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>7</u> Min. <u>2</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Thomas D. Greely</u>				14. MOTHER'S MAIDEN NAME <u>Margaret E. Hartline</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Thomas J. Greely</u> Address <u>19 McCormick Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MALNUTRITION</u> <u>753.1</u> DUE TO <u>(MICROCEPHALY)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGENITAL MALFORMATION OF BRAIN</u> DUE TO (c) <u>7 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(Maximum weight during life: 9 lb 8 oz. Birth weight: 6 lb 8 oz.)</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>2/26 1954</u> to <u>6/28 1961</u> , that (I) (we) last saw the deceased alive on <u>6/28 1961</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John W. Machen</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/28/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN W. MACHEN M.D.</u>				22d. ADDRESS <u>6331 BELAIR ROAD (6) BALTO. CITY</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JUNE 30 61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER CEM</u>		23d. LOCATION (City, town, or county) (State) <u>4430 BELAIR RD MD BALTO</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Dippel Bros</u>				25a. REC'D BY REGISTRAR <u>JUN 30 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton S. Kinn</u>	

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CERTIFICATE OF DEATH

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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH  
 06466

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>IRVING</b> Middle <b>RANDOLPH</b> Last <b>GREEN</b>				4. DATE OF DEATH Month <b>6</b> Day <b>16</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-21-90</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>16</b> Hours <b>16</b> Min.		11. IF UNDER 24 HRS. Months <b>7</b> Days <b>16</b> Hours <b>16</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LINEMAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>			
11. BIRTHPLACE (State or foreign country) <b>MD</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JOHN R. GREEN</b>				14. MOTHER'S MAIDEN NAME <b>CHRISTIE F. BROWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-01-5134</b>			
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>				Address <b>—</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTASIS (GENERALIZED)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF PROSTATE</b> DUE TO (c) <b>—</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002X PULMONARY TUBERCULOSIS, SENILITY</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>				20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>			
20f. (City or town) <b>—</b>				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>12-1-1960</b> to <b>6-16-1961</b> , that (I) (we) lost saw the deceased alive on <b>6-17-1961</b> , and that death occurred of <b>4:20 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm. Newcomer</b>				22b. DATE SIGNED <b>6-17-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D. Superintendent</b>				22d. ADDRESS <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/19/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Taylor Ave, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Austin E. Donovan</b>				25a. REC'D BY REGISTRAR <b>—</b>			
25b. REGISTRAR'S SIGNATURE <b>—</b>				25c. DATE <b>JUN 22 '61</b>			

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CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6483

06467

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>99 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1000 Warner Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
<b>3. NAME OF DECEASED</b> (Type or print) First <b>ROY</b> Middle <b>(NMI)</b> Last <b>GREEN</b>				<b>4. DATE OF DEATH</b> Month <b>JUNE</b> Day <b>11</b> Year <b>19 61</b>										
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Colored</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>6/20/90</b>		<b>9. AGE</b> (In years last birthday) <b>70</b> yrs. <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Ellaville, Georgia</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				
<b>13. FATHER'S NAME</b> <b>Goad Green</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Katie Burden</b>										
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>WW I</b>				<b>16. SOCIAL SECURITY NO.</b> <b>255-26-7205</b> <b>17. INFORMANT</b> <b>Clin. Rec. VAH, Balto. Md. Ft. Howard Division</b>										
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURED ESOPHAGEAL VARICES</b> (b) <b>LAENNEC'S CIRRHOSIS</b> (c) <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>SEVERAL YEARS</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>		
<b>21. I certify that</b> (this hospital) <b>attended the deceased from March 4, 1961, to June 11, 1961</b> that (we) saw the deceased alive on <b>June 11, 1961</b> , and that death occurred at <b>6:30AM</b> from the causes and on the date stated above.														
<b>22a. SIGNATURE</b> <b>Joseph J. Cillo M.D.</b> M.D.						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>			<b>22b. DATE SIGNED</b> <b>6/11/61</b>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>JOSEPH J. CILLO, M.D.</b>						<b>22d. ADDRESS</b> <b>VAH, BALTO. MD. FORT HOWARD DIVISION</b>								
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>6-15-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National</b>				<b>23d. LOCATION (City, town or county) (State)</b> <b>Baltimore, Maryland</b>				
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Arlington S. Phillips</b>						<b>ADDRESS</b> <b>1808 N. Monroe St. Baltimore, Maryland</b>			<b>25a. REC'D BY REGISTRAR</b> <b>DATE JUN 14 '61</b>			<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06468

6484

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> <span style="float: right;">c. LENGTH OF STAY IN 1b <u>2 days</u></span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Training School</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 14,</u> d. STREET ADDRESS <u>7812 Wendover Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Dale Wayne Groth</u>		<b>4. DATE OF DEATH</b> Month <u>6</u> Day <u>8</u> Year <u>19 61</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>6/29/60</u>		<b>9. AGE</b> (In years last birthday) <u>11</u> yrs. <span style="float: right;">IF UNDER 1 YEAR</span> Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Dependent</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>John David Groth</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>June Landonia Kerr</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>---</u>		<b>17. INFORMANT</b> <span style="float: right;">Address</span> <u>Rosewood Records, Owings Mills, Md.</u>									
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Marked Hydrocephalus</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Hour <u>e.m.</u> Month, Day, Year <u>19</u> p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at <u>4:50 PM</u> on..... the causes and on the date stated above.															
<b>22a. SIGNATURE</b> <u>Peter W. Rieckert</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>6-9-61</u>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Peter W. Rieckert</u>						<b>22d. ADDRESS</b> <u>4307 Mainfield Ave Baltimore</u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>6-12-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Gardens of Faith Cem.</u>				<b>23d. LOCATION</b> (City, town or county) <u>Baltimore Md.</u> <span style="float: right;">(State)</span>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John C. Miller</u>						<b>ADDRESS</b> <u>2431-35 E. Oliver St.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JUN 13 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thoma</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6485 CERTIFICATE OF DEATH 06469											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN lb <b>7 yrs.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore - Mt. Washington</b>				d. STREET ADDRESS <b>Mt. St. Agnes College</b> <b>5801 Smith Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address) <b>Stella Maris Hospice</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Rosie</b>			First Middle Last <b>Guercia</b>			4. DATE OF DEATH <b>6/29/</b>			Month Day Year <b>19 61</b>		
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/1/1887</b>		9. AGE (In years last birthday) <b>73 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>			12. CITIZEN OF WHAT COUNTRY? <b>Italy.</b>		
13. FATHER'S NAME <b>A ntonia Guercia</b>				14. MOTHER'S MAIDEN NAME <b>Conchetta</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>219-30-9199</b>		17. INFORMANT <b>Admission Record</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>260X</b> IMMEDIATE CAUSE (a) <b>myocardial infarction</b> <b>ASCVD</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Diabetes mellitus</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>260X</b>										INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>years?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
22c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/29 19 61</b> to <b>6/29 19 61</b> , that (I) (we) last saw the deceased alive on <b>6/29 19 61</b> , and that death occurred at <b>11:15 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>George H. Beck</b>				M.D. <b>George Beck M. D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6/29/61</b>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <b>6012 Harford Rd, Balto, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7-1-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. St. Agnes Convent cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Mt. Washington, Balto. Md</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook* Towson, Inc., 1050 York Road, Towson 4</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>JUL 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

00000

(M)

(I)

Mr. Cook-Townsend, Inc., 1050 York Road, Townsend  
V-1-61  
Mr. St. James Company  
Mr. Washington, Baltimore  
George Book N. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6485

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06470

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>6mth15days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>			d. STREET ADDRESS <b>1352 Washington Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Olive</b> Middle <b>V</b> Last <b>Hale</b>			4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>19 61</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 13, 1873</b>	9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Unknown Caleb Bowdle</b>			14. MOTHER'S MAIDEN NAME <b>Unknown Helen Barwick</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Congestive heart failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular disease</b> DUE TO (c) <b>Pneumonia</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>On 3-13-61 pt. fell to floor from chair sustaining a frac. of the left femur</b>			
20c. TIME OF INJURY Hour <b>7:15</b> AM <input checked="" type="checkbox"/> PM <input type="checkbox"/> Month, Day, Year <b>3-13 1961</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hospital</b>		20f. (City or town) (County) (State) <b>Catonsville 28, Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Geo. M. Kieffer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6-8-61</b>	
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-12-1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Abingdon Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home 7401 Belair Road</b>			24a. REC'D BY REGISTRAR DATE <b>JUN 12 '61</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Hines</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the medical examiner, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

6/28  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oella</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		d. STREET ADDRESS <b>Ellicott City</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>BARNES</b> Middle <b>ERNEST</b> Last <b>HAMILTON</b>				4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>19 61</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>unknown Age: 40</b>		9. AGE (In years last birthday) <b>40 yrs.</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>14</b> Hours <b>14</b> Mins. <b>40</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>Reeves Hamilton</b>				14. MOTHER'S MAIDEN NAME <b>Alice Branhan</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Cheaton Funeral Home, Lynchburg, Va</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b> 976X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in head</b>																	
20c. TIME OF INJURY Month, Day, Year <b>6:20 p.m. 6/4/ 19 61</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Woods</b>				20f. (City or town) (County) (State) <b>Oella, Baltimore, Maryland</b>									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>6/5/61</b>									
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>				ADDRESS <b>1217 St. Paul Street</b>				22b. LOCATION (City, town, or country) (State) <b>Amherst County, Virginia</b>				22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Episcopal Mission Cemetery</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>				22b. DATE THEREOF <b>6-19-61</b>				22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Episcopal Mission Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Amherst County, Virginia</b>									
23. FUNERAL DIRECTOR <b>Wm. Cook, Inc., 1217 St. Paul Street</b>				ADDRESS <b>1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR <b>JUN 20 '61</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>									





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6488

## CERTIFICATE OF DEATH

06472

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>34 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore -6</b>		d. STREET ADDRESS <b>8533 Philadelphia Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>R.</b> Last <b>HAMMER</b>				4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 30, 1895</b> <b>65</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Can Mfg. Company</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph G. Hammer</b>				14. MOTHER'S MAIDEN NAME <b>Ella Jane Beeks</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>215-05-5216</b>		17. INFORMANT <b>Clinical Folders</b> Address <b>3900 Loch Raven Blvd. Balto 18, Md. -FORT HOWARD DIVISION</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO (b) <b>PORTAL CIRRHOSIS OF LIVER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>581.0</b>				INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>ARTERIOSCLEROTIC HEART DISEASE -Duration Unknown</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 5, 1961</b> , to <b>June 8, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 8, 1961</b> , and that death occurred at <b>3:16 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Thomas F. Crahan</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE <b>6/9/61</b>	
22c. PHYSICIAN'S NAME <b>THOMAS F. CRAHAN, M.D.</b>				22d. ADDRESS <b>VAH, Fort Howard, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/12/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook-Blight, Inc.</b>				25a. REC'D BY REGISTRAR <b>6009 Harford Road Baltimore, Maryland</b> DATE <b>JUN 12 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1943

OFFICE OF THE DIRECTOR

1943

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REPORT OF THE DIRECTOR  
ON THE PROGRESS OF THE  
WORK OF THE OFFICE OF THE  
DIRECTOR DURING THE YEAR  
1943

For the year 1943, the  
Office of the Director has  
been engaged in the study  
of the problem of the  
control of the spread of  
the disease known as  
"Typhoid Fever".

The work of the Office  
has been directed towards  
the study of the disease  
and the methods of its  
control. The results of  
this work are set forth  
in the following report.

THOMAS F. CRANE, M.D.  
Director

1943

Office of the Director  
1000 Maryland Road  
Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6489 CERTIFICATE OF DEATH 06473											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Forest Haven Nursing Home</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore County</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>Formerly of Towson, Maryland</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Martha Susan Hardesty</b>			4. DATE OF DEATH <b>June 29, 1961</b>			5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>June 26, 1871</b>			9. AGE (In years last birthday) <b>90 yrs.</b>			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>		
13. FATHER'S NAME <b>James Keiningham</b>			14. MOTHER'S MAIDEN NAME <b>Lucy ?</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>No</b>		
17. INFORMANT <b>Mrs. Robert Rector-400 Hopkins Road</b>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>ARTERIOSECULAR HYPERTENSION</b> DUE TO (c) <b>PULMONARY EDEMA - PNEUMONIA</b> <b>DIPHTHERIA</b>			INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>6/1/61</b> to <b>6/29/61</b> , that (I) (we) last saw the deceased alive on <b>6/29/61</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>John H. Shaw</b>						22b. DATE SIGNED <b>6/30/61</b>			22c. PHYSICIAN'S NAME (Type) <b>John H. Shaw M.D.</b>		
22d. ADDRESS <b>880 E. E. Shaw Ave. H.L.S. Inn</b>			23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>								
23b. DATE THEREOF <b>7-1-61</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>			25a. REC'D BY REGISTRAR <b>Jul 3 '61</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Zick...</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			25c. DATE <b>Jul 3 '61</b>			25d. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
6490 06474											
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Raspeburg</i>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>5302 Mc Cormick Avenue</i>						d. STREET ADDRESS <i>5302 Mc Cormick Avenue</i>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <i>Mr. William James Harps</i>						4. DATE OF DEATH <i>June 29th 19 61</i>					
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 17, 1909</i>		9. AGE (In years last birthday) <i>51</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maintenance</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Armco Steel Co</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>?</i>						14. MOTHER'S MAIDEN NAME <i>?</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>?</i>						16. SOCIAL SECURITY NO. <i>212-08-7072</i>					
17. INFORMANT <i>Mrs. Josephine Harps</i>						Address <i>same</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory insufficiency</i> 163X DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Cancer of the lungs</i> (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>6-29-61</i> , 19 <i>61</i> , to <i>6-29-61</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>6-29-61</i> , and that death occurred at <i>7A</i> M., from the causes and on the date stated above.											
22a. SIGNATURE <i>Dr John Geldrich</i> M.D.						22b. DATE SIGNED <i>6-29-61</i>					
22c. PHYSICIAN'S NAME (Type) <i>Dr. John Geldrich</i>						22d. ADDRESS <i>8019 Philadelphia Road, Balto. 6, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>7-1-61</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>		
24 FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>						25a. REC'D BY REGISTRAR <i>JUL 3 '61</i>					
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>											

1932

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1932 Philadelphia

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1932 Philadelphia



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
6491										
06475										
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>—</b> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>			c. LENGTH OF STAY IN 1b <b>5 MONTHS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			d. STREET ADDRESS <b>115 E. MELROSE AVE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MASONIC HOME</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>LOLA M HAYDEN</b>					4. DATE OF DEATH Month <b>JUNE</b> Day <b>30</b> Year <b>1961</b>					
5. SEX <b>FE</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-5-1883</b>		9. AGE (In years last birthday) <b>78</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
13. FATHER'S NAME <b>GEORGE MEREDITH</b>					14. MOTHER'S MAIDEN NAME <b>MARY TARMAN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-28-5118</b>		17. INFORMANT Name <b>Frank X. Smith Jr.</b> Address <b>Cockeysville, Md.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Acute Atherosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>5 months</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>2-7</b> , 19 <b>61</b> , to <b>6-30</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>6-30</b> , 19 <b>61</b> , and that death occurred at <b>5:25 P</b> , from the causes and on the date stated above.										
22a. SIGNATURE <b>Walter T. Kees</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6/30/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>					22d. ADDRESS <b>COCKEYSVILLE MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 3, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc. 1217 St. Paul St.</b>					ADDRESS		25a. REC'D BY REGISTRAR <b>JUL 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>	

Wm. Cook, Inc. 1217 St. Paul St.

July 3, 1951

Baltimore, Md.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6492

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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>Daklee Village Apt. 15 # 29</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Frederick Heiner</u>		4. DATE OF DEATH <u>June 4, 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1868</u>
9. AGE (In years last birthday) <u>92 yrs.</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Shipping Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Butler Brothers</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John J. Heiner</u>	
14. MOTHER'S MAIDEN NAME <u>Fredericka Mahr</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Miss Etta Heiner-Apt. 15 Oaklee Village</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchitis - Pneumonia</u> DUE TO (b) <u>Generalized Arterio Sclerosis Cardiovascular</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>519</u>	20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>5/19</u> to <u>6/4</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6/4</u> , 19 <u>61</u> , and that death occurred at <u>8:20 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph G. Laukaitis</u> M.D.		22b. DATE SIGNED <u>6/5/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph G. Laukaitis</u>		22d. ADDRESS <u>679 Washington Boulevard</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-8-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Tackewicz-Son</u>		25a. REC'D BY REGISTRAR <u>North Penna Ages Balto Md</u>	25b. REGISTRAR'S SIGNATURE <u>  </u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>✓</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <i>3V0.1.4</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Josephs Nurs. Home</b>				d. STREET ADDRESS <b>3065 Strickland St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>E. Heinmuller</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>1961</b>							
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 26, 1871</b>		9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>O8Brien</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs G.R.Flatt, 10 Boone Trail, Severna Pk.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CA of Rectum</b> <b>154X</b> DUE TO <b>with Metastases to Liver</b> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3-1-61</b> 19 <b>61</b> , to <b>6-16</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>6-16</b> 19 <b>61</b> , and that death occurred at <b>7P</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>James E. Howell</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6-17-61</b>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <b>Catonsville</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/19/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemty.</b>		23d. LOCATION (City, town, or county) <b>Balto. Md.</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D.4101 Edmondson Ave.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>JUN 20 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>6yr3mthldy</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>535 S. Fulton Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Fred Heinzenberger</b> First Middle Last 4. DATE OF DEATH <b>June 23, 1961</b> Month Day Year		5. SEX <b>male</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>August 24, 1885</b> 9. AGE (In years last birthday) <b>75</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ba ker</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b> 11. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b> 12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <b>Conrad Heinzenberger</b> 14. MOTHER'S MAIDEN NAME <b>Mary Heinzenberger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>none</b> 16. SOCIAL SECURITY NO. <b>none</b> 17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute heart failure</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (X) (this hospital) attended the deceased from <b>June 23, 1961</b> , to <b>June 23, 1961</b> , that (X) (we) last saw the deceased alive on <b>June 23, 1961</b> , and that death occurred at <b>10pm</b> , from the causes and on the date stated above.	
22a. SIGNATURE <b>Jose R. Arizaga</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>JOSE R. ARIZAGA, M.D.</b>		22b. DATE SIGNED ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>6/27/61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Western</b> 23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D. 4101 Edmondson Ave.</b> 25a. REC'D BY REGISTRAR <b>JUN 26 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

VR A15 (4)  
15M 9/60

11413

11413

(M)

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Acute heart failure  
Arteriosclerotic cardiovascular  
Disease

11413  
11413  
11413

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
6495 CERTIFICATE OF DEATH 06479															
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Shady Nook Nursing Home</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville Baltimore</b> d. STREET ADDRESS <b>2012 Whittier Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Le Roy F. Hendricks</b>				4. DATE OF DEATH <b>June 17, 1961</b>				5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>Oct. 5, 1885</b> 9. AGE (In years last birthday) <b>75 yrs.</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.							
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Capitol Cake Co.</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Eli Hendricks</b>				14. MOTHER'S MAIDEN NAME <b>Harriet S. Fleck</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>213-26-1801</b>				17. INFORMANT <b>Mrs. Edith B. Mc Clure-729 Cator Avenue</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Carcinoma of prostate</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <b>Arteriosclerosis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>June 16, 1961</b> , to <b>June 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 16, 1961</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>Dr. D. C. Mac Laughlin</b>				22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type) <b>Dr. D. C. Mac Laughlin</b>				22d. ADDRESS <b>4508 Edmondson Avenue Baltimore, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6-20-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Tackes &amp; Sons</b>				25a. REC'D BY REGISTRAR <b>North Penna Ave Balto 17, Md</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>				DATE <b>JUN 19 '61</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6495

## CERTIFICATE OF DEATH

Reg. Dist. No. 06480

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>X CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Hickman</u> Middle <u>Hickman</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/25/1876</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FUNERAL-BUSINESS</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>GEORGE W. HICKMAN</u>		14. MOTHER'S MAIDEN NAME <u>SARAH E. MORGAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MR. HERBERT S. HICKMAN</u>		18. ADDRESS <u>2107 Meadow View Drive (7)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>Cerebrovascular Occlusion.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic changes.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>6/24/61 - 10 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 1960</u> , to <u>June 29, 1961</u> , that I last saw the deceased alive on <u>June 29, 1961</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>6-30-61</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>		M.D. <u>6014 Elmwood Ave</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/3/1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LONDON PARK CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. TRUMAN Schwab</u>		ADDRESS <u>3512 Frederick Ave. (29)</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

<p>1. Name of deceased: <u>William</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of death: <u>Jan 15 1911</u></p>	
<p>5. Place of death: <u>Home</u></p>		<p>6. Cause of death: <u>Heart</u></p>	
<p>7. Occupation: <u>Teacher</u></p>		<p>8. Usual place of abode: <u>Home</u></p>	
<p>9. Name of physician: <u>Dr. J. W. Smith</u></p>		<p>10. Name of undertaker: <u>John Doe</u></p>	
<p>11. Name of informant: <u>John Doe</u></p>		<p>12. Signature of informant: <u>[Signature]</u></p>	
<p>13. Name of registrar: <u>John Doe</u></p>		<p>14. Signature of registrar: <u>[Signature]</u></p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ISM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6497 CERTIFICATE OF DEATH 06481											
Items 21 & 22 Film G-89 6/27/61 ink											
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baynesville</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baynesville</i>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>8705 Emge Road</i>				d. STREET ADDRESS <i>8705 Emge Road</i>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John J. Hiebler</i>				4. DATE OF DEATH <i>June 18th 19 61</i>							
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Mar. 19, 1887</i>		9. AGE (in years last birthday) <i>74 yrs.</i>		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Carpenter</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Peter Hiebler</i>				14. MOTHER'S MAIDEN NAME <i>Mary Reisin</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes give year or dates of service)</i>				16. SOCIAL SECURITY NO. <i>218-18-5358</i>				17. INFORMANT <i>Mrs. Ella M. Hiebler</i> Address <i>same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Acute Myocardial Infarction</i> Conditions, if any, which gave rise to immediate cause (b) <i>Arteriosclerotic CVD</i> (c) DUE TO <i>20 yrs</i> cause last.				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>5 min</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1-18, 1961</i> to <i>6-18, 1961</i> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>6-14, 1961</i> , and that death occurred at <i>5P</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Joseph F. Hiebler M.D.</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>June 18/61</i>			
22c. PHYSICIAN'S NAME (Type) <i>Joseph F. Hiebler</i>				22d. ADDRESS <i>8400 Loch Raven Blvd Balto 4, Md</i>							
23a. BURIAL, CREMATION, REMOVAL, (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6/21/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem Park</i>				23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Road #14</i>				25a. REC'D BY REGISTRAR <i>JUN 20 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

18830

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Leonard J. Beck 2305 Hartford Road N.Y.

2/21/79

Moreland in Paris

Beck and New York

JUN 21 1979

10-10-78 Mrs. L. Beck

Beck

Beck and Co. Inc.

10-10-78

1/21/79

10-10-78

Beck and Co. Inc.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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6498  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06482

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville, Md.</b>				c. LENGTH OF STAY IN 1b <b>5/7/57</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Caton Ridge Nursing Home</b>				e. STREET ADDRESS <b>329 Harlem Lane (411 Nelson St.)</b>			
3. NAME OF DECEASED (Type or print) First <b>Lieu</b> (also <b>Luh Ham</b> ) Middle <b>HIM</b> Last <b>MIN</b>				4. DATE OF DEATH Month <b>6</b> Day <b>23</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Yellow</b> CHINA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chef</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>China</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Robert Lew White Rice Inn Park Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio sclerosis</b> DUE TO (c) <b>Hypertensive heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Insufficiency - left ventricle</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 7</b> 19 <b>57</b> to <b>June 23</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>June 21</b> 19 <b>61</b> , and that death occurred at <b>12:25</b> P. M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Cliff Ratliff, Jr.</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6/23/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFF, JR.</b>				22d. ADDRESS <b>4605 EDMONDSON AVE #29</b>			
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial June 26/61</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Woodlawn</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Stewart Moore</b>				25a. REC'D BY REGISTRAR <b>JUN 26 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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(I)

MEDICAL CERTIFICATION



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22 Film G289 6/28/61 iwk

## CERTIFICATE OF DEATH

Reg. Dist. No. 06483

6493

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>23yrs/4mth/26dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bertha</b> Middle <b>Hobby</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 17, 1901</b>
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Shanks</b>		14. MOTHER'S MAIDEN NAME <b>Julia Shanks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Insufficiency</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 10, 1961</b> , to <b>June 7, 1961</b> , that I last saw the deceased alive on <b>June 7, 1961</b> , and that death occurred at <b>2:20 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Loretta Hsu</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 6-8-61</b>	
PHYSICIAN'S NAME (Type) <b>Loretta Hsu, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>6/15/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion, August</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Zion, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.H. McKee Funeral Home - Augusta, W.Va.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 9 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hsu</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
6500											
06484											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Parkville</u> d. STREET ADDRESS <u>3224 Putty Hill Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>W. Hubbard, Sr.</u> Last <u></u>						4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>19 61</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-27-1876</u>		9. AGE (in years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. tug Boat Capt.</u>						10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Hubbard</u>						14. MOTHER'S MAIDEN NAME <u>Rose Fitzpatrick</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes give year or dates of service) <u></u>						16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs Margaret E. Kunkel</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422-1 Atherosclerotic Cardiovascular Disease</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u>						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) <u></u>					
20c. TIME OF INJURY Hour <u></u> e.m. <u></u> p.m. <u></u> Month, Day, Year <u>19 61</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <u></u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6-12-61</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u></u>											
ACTUAL SIGNATURE <u>John C. Hyle</u>		EXAMINER'S NAME (Type) <u>JOHN C. HYLE</u>		M.D. <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6-14-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or country) <u>Baltimore, Md.</u>		(State) <u></u>			
23. FUNERAL DIRECTOR <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u>						24a. REC'D BY REGISTRAR <u></u> DATE <u>JUN 13 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kunkel</u>			

*[Faint, illegible text from the reverse side of the page]*

6501

## CERTIFICATE OF DEATH

06485

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>3 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Foxleigh Nursing Home</u>		d. STREET ADDRESS <u>340 Central Ave. 1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Luella Hull</u>		4. DATE OF DEATH Month Day Year <u>June 26 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/14/1878</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Stall</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Jane Brolow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Glyndow Eckhardt</u>		Address <u>Glyndow, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> <u>900.0</u> DUE TO <u>with metastases to liver</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>to aches in</u> DUE TO (c) <u>Fracture of st. hip about 5 mos ago</u> <u>Fracture pinned.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Probably 1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>info indicates De compensation 5 yrs</u> <u>large Descending aortic aneurysm</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>—</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on sharp barbed wire</u>	
20c. TIME OF INJURY Month Day Year <u>5 p.m. Feb 19 1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Glyndow Baltimore Md</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>5-6-1961</u> to <u>6-26-1961</u> , that (I) (we) last saw the deceased alive on <u>5-6-1961</u> , and that death occurred at <u>12:00</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>James H. Saffell</u>		22b. DATE SIGNED <u>6-26-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>James G. Saffell MD</u>		22d. ADDRESS <u>Reisterstown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/29/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Kriders Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Westminster Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry James Eckhardt</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 29 '61</u>	
ADDRESS <u>Owings Mills</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

(M)

Baltimore

Pikesville

3 months

Forster's Nursing Home

Marquand Hotel

Female White

Housekeeper

Henry Stahl

(1)

Howe

Capitol Building

Garrison Co, Maryland 1124

Eliza Jane Brown

June 22 1911

340 Central Ave

Goldboro

Maryland

Baltimore

1911

1911

Henry James Colwell Curran Wells

Bureau of Census

Washington

1911

1

6502

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06486

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>-</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>3 1/2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		d. STREET ADDRESS <b>1900 CHELSEA RD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>NELLIE GRAY JONES</b>		4. DATE OF DEATH Month Day Year <b>JUNE 25 1961</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 12, 1891</b>
9. AGE (In years lost birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>WILLIAM A. GRAY</b>		14. MOTHER'S MAIDEN NAME <b>MARY JANE WIDOP</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Frank L. Smith</b> Address <b>Cockeysville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Vascular Accident</b> <b>422.01</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral &amp; Generalized Arterio Sclerosis</b> 3 1/2 years DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-22</b> 19 <b>57</b> , to <b>6-25</b> 19 <b>61</b> , that (I) (we) lost saw the deceased alive on <b>6-24 1961</b> , and that death occurred at <b>1 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter T. Kees</b> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>6/25/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>		22d. ADDRESS <b>COCKEYSVILLE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>6-27-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wm. Cook, Inc., 1217 St. Paul Street, Zone 2</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 27 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

00486

STATE OF OHIO

1902

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BALTIMORE

MARION C. BOWEN

WILLIAM A. GRAY

MARY JANE WILSON

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MARY JANE WILSON



## CERTIFICATE OF DEATH

Reg. Dist. No. **06487**

6503

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Overlea</b>		c. LENGTH OF STAY IN 1b <b>4 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4704 Meise Dr.</b>		d. STREET ADDRESS <b>4704 Meise Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Stephen</b> Middle <b>Paul</b> Last <b>KACEN</b>		4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1915</b>
9. AGE (In years last birthday) yrs. <b>46</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tech. Editor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Martin's</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			
13. FATHER'S NAME <b>Stephen ?</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or date of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>152-10-5736</b>	
INFORMANT Address <b>Kathleen Edith Kacen-4704 Meise Dr.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 1961, to <b>June</b> , 1961, that I last saw the deceased alive on <b>6/17</b> , 1961, and that death occurred at <b>3:44</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. Clark Holmes</b>		ADDRESS (Street, city or town, state) <b>8019 Philadelphia Rd. #4</b> DATE SIGNED <b>6/22/61</b>	
PHYSICIAN'S NAME (Type) <b>A. Clark Holmes</b>		<b>8019 Philadelphia Rd.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-24-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glenlake Cemetery</b>
22d. LOCATION (City, town, or county) (State) <b>Bloomfield, New Jersey</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip E. Coach</b> ADDRESS <b>1211 Chesebo Ave.</b>		24a. REC'D BY REGISTRAR <b>JUN 26 61</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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OFFICE OF THE DIRECTOR

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James - Walter

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
6504														
06488														
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					b. COUNTY Baltimore									
c. LENGTH OF STAY IN 1b Baltimore					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5123 Montbel Ave.					d. STREET ADDRESS 5123 Montbel Ave.									
3. NAME OF DECEASED (Type or print) Edna O Kammer					4. DATE OF DEATH June 15 1961									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 2, 1887		9. AGE (In years last birthday) 73 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY U. S. A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13. FATHER'S NAME Nicholas Weller					14. MOTHER'S MAIDEN NAME Susetta ?									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO. 215-09-4112A					17. INFORMANT Mr. G. Donald Kammer, 1306 Breezy Lane N. E. Atlanta 6, Ga.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Carcinoma Colon										INTERVAL BETWEEN ONSET AND DEATH 6 wks.				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		20g. (County) Baltimore					
21. I certify that (I) (this hospital) attended the deceased from 6/12, 1961, to 6/15, 1961, that (I) (we) last saw the deceased alive on 6/15, 1961, and that death occurred at 10:00 P.M. from the causes and on the date stated above.														
22a. SIGNATURE L H Golombek					22b. ADDRESS 7039 Liberty Rd.		22c. PHYSICIAN'S NAME (Type) Leonard H. Golombek			22d. DATE SIGNED JUN 19 1961				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 6-15-61		23c. NAME OF CEMETERY OR CREMATORY London Park Baltimore, Md.			23d. LOCATION (City, town or county) Baltimore, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiebner & Sons, Baltimore, Md					25a. REC'D BY REGISTRAR JUN 19 1961		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06488

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PARKTON</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PARKTON</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MT. CARMEL RD</b>				d. STREET ADDRESS <b>MT. CARMEL RD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES A-KEIL</b>				4. DATE OF DEATH Month Day Year <b>JUNE 9 1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY-28, 1878</b>		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FOREMAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>SEWING FACTORY</b>		11. BIRTHPLACE (State or foreign country) <b>NEW JERSEY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>HERMAN H. KEIL</b>				14. MOTHER'S MAIDEN NAME <b>DIEGLE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-01-272</b>		17. INFORMANT <b>ANNETTA K. MAYO - MT. CARMEL RD</b>		Address <b>PARKTON</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> to <b>June 9, 1961</b> , that (I) (we) lost the deceased on <b>June 9, 1961</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>G. M. France</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6/9/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. M. FRANCE</b>				22d. ADDRESS <b>PARKTON, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-12-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MORELAND PK</b>		23d. LOCATION (City, town, or county) (State) <b>TAYLOR AVE - BALTO. MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. M. Cook-Tolson - YORK RD - TOLSON - 4 MD</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JUN 12 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6506

06490

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN b <b>1 Day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>516 S. Macon Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>(Served as GUST J. KELLY KELLIS)</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>June 15 19 61</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>November 16, 1887</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Restaurant Worker</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Restaurant</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Greece</b>
<b>13. FATHER'S NAME</b> <b>John Kelly</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWI</b>		<b>16. SOCIAL SECURITY NO.</b> <b>VAH, BALTO., MD., FORT HOWARD DIVISION 18</b>	
<b>17. INFORMANT</b> <b>Carrie MN: Unknown</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE, RIGHT, MASSIVE</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE FAILURE</b> (c) <b>PEPTIC ULCER, STOMACH,</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>BENIGN PROSTATIC HYPERTROPHY- DURATION UNKNOWN</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 14, 1961</b> to <b>June 15, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 15, 1961</b> , and that death occurred at <b>6:21 P.M.</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Thomas F. Crahan</b> M.D.		<b>22b. DATE SIGNED</b> <b>6/15/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>THOMAS F. CRAHAN, M.D.</b>		<b>22d. ADDRESS</b> <b>VAH, BALTIMORE, MD. - FT HOWARD DIV.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>		<b>23b. DATE THEREOF</b> <b>6-15-61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Upland Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Yorkville Ohio</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JUN 20 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. ...</b>			

SHIPPED TO: Burford Funeral Home, 102 Main St. Tiltonville, Ohio

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TO: **INITIAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO: **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6507					CERTIFICATE OF DEATH						
06491											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>33 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2408 E. Lafayette Avenue (13)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>FRED E. KING</b>					4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>19 61</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 29, 1888</b>		9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days <b>19 61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Liquor</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Oshkosh, Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Casper King</b>					14. MOTHER'S MAIDEN NAME <b>Marie Ruckenstraugh</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>					16. SOCIAL SECURITY NO. <b>213-07-5711</b>		17. INFORMANT Address <b>Clin. Rec. VAH, BALTIMORE 18, MD., FT. HOWARD DIV.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY INSUFFICIENCY</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>HODGKIN'S DISEASE, ABDOMINAL</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 5 1961</b> to <b>June 7 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 7 1961</b> , and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Thomas F. Crahan</b> 22c. PHYSICIAN'S NAME (Type or print) <b>THOMAS F. CRAHAN, M.D.</b>					22b. DATE SIGNED <b>6/7/61</b> 22d. ADDRESS <b>VAH, BALTO. 18, MD., FORT HOWARD DIVISION</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-12-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore</b>		23d. LOCATION (City, town or county) (State) <b>28, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leo G. Cook, 1700 N. Patterson Park Ave.</b>					25a. REC'D BY REGISTRAR DATE <b>JUN 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Clifford L. Kraus</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06492

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		d. STREET ADDRESS <u>10 EAST PRATT STREET</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARL</u> <u>GEORGE</u> <u>KIRMES</u>		4. DATE OF DEATH Month Day Year <u>JUNE</u> <u>8</u> <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 16 1903</u>
9. AGE (In years lost birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARINE ENGINE SALES ROOM</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CARL KIRMES</u>		14. MOTHER'S MAIDEN NAME <u>JOHANNA STRUHS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-07-5320</u>	
17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of left lung</u> DUE TO (b) <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>163X</u> DUE TO (c) <u>163X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary tuberculosis. Emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>002X</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/16</u> <u>1961</u> to <u>6/8</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>6/8</u> <u>1961</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm. Newcomer</u>		22b. DATE SIGNED <u>6/9/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D. Superintendent</u>		22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/12/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE.</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO CO.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Paul E. [Signature]</u>		25a. REC'D BY REGISTRAR <u>DATE 12 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. [Signature]</u>			

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CERTIFICATE OF DEATH

2023

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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06493

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> <b>12 Days</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (14) 3001-4</b> d. STREET ADDRESS <b>3209 Glenmore Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>JACOB P. KRACH</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>June 15 19 61</b> Month Day Year									
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>May 12, 1880</b>		<b>9. AGE</b> (In years last birthday) <b>81 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Steel Construction</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Gardenville, Maryland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Phillip Krach</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Otto</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>						<b>16. SOCIAL SECURITY NO.</b> <b>212-01-6196</b>						<b>17. INFORMANT</b> <b>Clin. Records, VAH, Balto. Md. Ft. Howard Div.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE FAILURE</b> (b) <b>PULMONARY EMPHYSEMA</b> (c) <b>NEPHROSCLEROSIS, ARTERIOSCLEROTIC</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. _____ 19____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that</b> <b>10</b> (this hospital) attended the deceased from <b>June 3, 1961</b> , to <b>June 15, 1961</b> , that <b>10</b> (we) last saw the deceased alive on <b>June 15, 1961</b> , and that death occurred <b>8:05AM</b> from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <i>Thomas F. Crahan</i>						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>6/15/61</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>THOMAS F. CRAHAN, M.D.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>6/19/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Parkwood Cemetery</b>				<b>23d. LOCATION</b> (City, town or county) <b>Baltimore, Maryland</b> (State)			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Heeman Funeral Home, 6067 Harford Rd., Balto. Md.</b>						<b>25a. REC'D BY REGISTRAR</b> <b>JUN 21 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Thomas</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Veterans Administration Hospital

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May 12, 1950

Special Communication Bureau, Virginia

Special Communication Bureau, Virginia

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Office of the Director, Federal Bureau of Investigation

Office of the Director, Federal Bureau of Investigation

UNITED STATES

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D.C.

WASHINGTON, D.C.

UNITED STATES

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D.C.

UNITED STATES

FEDERAL BUREAU OF INVESTIGATION

June 15, 1950

June 15, 1950

8:00 AM

8:00 AM

1950

THOMAS P. GOWAN, JR.

Baltimore, Maryland

Baltimore, Maryland

Baltimore, Maryland

June 15, 1950

Human Resources, 600 Maryland St., Baltimore, Md.

6510

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

06494

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <i>Sept 1960</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>610 Edmondson Ave.</b>				d. STREET ADDRESS <b>610 Edmondson Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dale</b> Middle <b>Levine</b> Last <b>Lambert</b>		4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>1961</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1960</b>	9. AGE (In years) <b>15 months</b>	IF UNDER 1 YEAR Months <b>15</b> Days <b>27</b> Hours <b>15</b> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert L. Lambert</b>				14. MOTHER'S MAIDEN NAME <b>Betty Turfle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Robert L. Lambert, 601 Edmondson Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GASTROENTERITIS, ACUTE</b> <b>571.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>5 HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PAROTITIS, LEFT, CHRONIC, RESOLVING</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>29 JUN 1960</b> , to <b>13 JUN 1961</b> , that (I) (we) last saw the deceased alive on <b>13 JUN 1961</b> , and that death occurred at <b>24 M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Irwin H. Moss, M. D.</i>				22b. DATE SIGNED <b>14 Jun 61</b>		22c. PHYSICIAN'S NAME (Type) <b>Irwin H. Moss, M. D.</b>	
22d. ADDRESS <b>5836 Baltimore Nat'l Pike</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 16, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westminster Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore 28, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Frank H. Newell, Pikesville, Md.</i>				25a. REC'D BY REGISTRAR <b>JUN 26 61</b>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>	

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CERTIFICATE OF MARRIAGE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6511

06495

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>903 Breezewick Road</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>903 Breezewick Road</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Middle First Middle</u> <u>Myrtle VERONICA Lee</u>		<b>4. DATE OF DEATH</b> Month <u>6</u> Day <u>16</u> Year <u>1961</u>	
<b>5. SEX</b> <u>F.</u>	<b>6. COLOR OR RACE</b> <u>W.</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>9-11-1898</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>	
<b>13. FATHER'S NAME</b> <u>JOSEPH W<sup>m</sup> Bolger</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>JULIA Fullem</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>101-11-1111</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Myocardial Degeneration</u> Conditions, if any, which gave rise to immediate cause (b) <u>Congestive heart failure.</u> (a), stating the underlying cause last. (c) <u>Generalized Arteriosclerosis</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> (County) (State) <u>Towson</u> <u>BALTIMORE</u> <u>Md.</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb</u> <u>1960</u> <b>to</b> <u>June</u> <u>1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>6/13/61</u> , <b>and that death occurred at</b> <u>9:30</u> <b>A.M.</b> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Frank T. Kasik</u>		<b>22b. DATE SIGNED</b> <u>6/16/61</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>FRANK T KASIK</u>		<b>22d. ADDRESS</b> <u>9005 Harford Rd</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>6/19/61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Holy Redeemer</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>BALTIMORE</u> <u>Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>L. J. RUCK</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Arthur S. Frank</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>5305 HARFORD RD.</u>		<b>DATE</b> <u>JUN 20 '61</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

6512

06496

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Haford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>5yr2mth24dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Joseph</b> Last <b>Leight</b>				4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>19 61</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1887</b> <b>Sept. 28, 1887</b>		9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>telegraph operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Leight</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Baungart</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-22-7192</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 7, 19 61</b> to <b>June 9, 19 61</b> that (I) (we) last saw the deceased alive on <b>June 9, 19 61</b> , and that death occurred at <b>1:40 p. M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Loretta Hsu</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6-9-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Loretta Hsu, M. D.</b>				22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/12/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		23d. LOCATION (City, town, or county) (State) <b>Bel Air, Harford, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard M. Conner</b>				25a. REC'D BY REGISTRAR <b>Abingdon</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **06497**

6513

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>				c. LENGTH OF STAY IN 1b <b>7 1/2 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN WILLIAM LEONARD</b>				4. DATE OF DEATH Month Day Year <b>JUNE 24 1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 3, 1870</b>		9. AGE (In years last birthday) yrs. <b>91</b>	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MILL WORKER</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>							
13. FATHER'S NAME <b>THOMAS LEONARD</b>				14. MOTHER'S MAIDEN NAME <b>MARY BATTY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>204-10-0085</b>		17. INFORMANT <b>Frank L. Smith Jr.</b> Address <b>Cockeysville, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Arterio Sclerotic Cardio</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Vascular Disease</b> DUE TO (c) <b>7 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-3</b> , 19 <b>53</b> , to <b>6-24</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>6-23</b> , 19 <b>61</b> , and that death occurred at <b>9:30 A.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Walter T. Kees</b> M.D. ADDRESS (Street, city or town, state) <b>Cockeysville, Md</b> DATE SIGNED <b>6/24/61</b> PHYSICIAN'S NAME (Type) <b>WALTER T. KEES COCKEYSVILLE MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-27-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville 8, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 27 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hous</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1941

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF BIRTH <i>Jan 15 1896</i>		6. PLACE OF BIRTH <i>Baltimore, Md</i>		7. DATE OF DEATH <i>Jan 15 1941</i>		8. PLACE OF DEATH <i>Baltimore, Md</i>	
9. OCCUPATION <i>Teacher</i>		10. CAUSE OF DEATH <i>Heart Disease</i>		11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF DECEASED <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>		31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF DECEASED <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF DECEASED <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>		43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>	
45. SIGNATURE OF DECEASED <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF DECEASED <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>		55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF DECEASED <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF DECEASED <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>		67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF DECEASED <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>		79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF DECEASED <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>		91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF DECEASED <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF DECEASED <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

17

THE DEPARTMENT OF HEALTH, BALTIMORE, MD, IS AN AGENCY OF THE STATE OF MARYLAND. IT IS THE POLICY OF THE DEPARTMENT TO PROVIDE FOR THE HEALTH AND WELFARE OF THE PEOPLE OF MARYLAND. THE DEPARTMENT IS COMPOSED OF THE BUREAU OF VITAL STATISTICS, THE BUREAU OF PUBLIC HEALTH, AND THE BUREAU OF LABOR AND INDUSTRY. THE BUREAU OF VITAL STATISTICS IS RESPONSIBLE FOR THE COLLECTION AND ANALYSIS OF VITAL DATA. THE BUREAU OF PUBLIC HEALTH IS RESPONSIBLE FOR THE PREVENTION AND CONTROL OF DISEASE. THE BUREAU OF LABOR AND INDUSTRY IS RESPONSIBLE FOR THE PROTECTION OF THE HEALTH AND SAFETY OF WORKERS. THE DEPARTMENT IS HEADQUARTERED IN THE STATE HOUSE, BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
6514														
6/28/61														
06498														
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN lb <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>105 S. Beechfield Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Douglas</b> First Middle Last <b>Leslie</b>					4. DATE OF DEATH <b>June 20 1961</b> Month Day Year									
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 28, 1895</b>		9. AGE (In years last birthday) <b>66</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>model maker machinist-Westinghouse</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Scotland</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b>							
13. FATHER'S NAME <b>John Leslie</b>					14. MOTHER'S MAIDEN NAME <b>Isabella Laing</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>					16. SOCIAL SECURITY NO. <b>015-03-7070</b>					17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarctive myocardial fibrosis</b> DUE TO 422.1 CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>Arteriosclerotic cardiovascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work ei work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>June 16 1961</b> to <b>June 20 1961</b> that (I) (we) last saw the deceased alive on <b>June 20 1961</b> , and that death occurred at <b>6:30 P.</b> from the causes and on the date stated above. 22a. SIGNATURE <b>Stella Wachsler</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>6-21-61</b> 22c. PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b> 22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL CATONSVILLE 28, Maryland</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/24/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>								
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b> ADDRESS <b>4107 Wilkens Avenue</b>					25a. REC'D BY REGISTRAR <b>JUN 23 '61</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6515

06499

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1505 Chilworth Avenue</u>		d. STREET ADDRESS <u>1505 Chilworth Avenue</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mrs. Sadie E. Mackley Lewis</u>		<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>10th</u> Year <u>19 61</u>	
<b>5. SEX</b> <u>female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Dec. 4, 1876</u>
<b>9. AGE</b> (In years last birthday) <u>84</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Henry Wooden</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Martha ?</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u> (If yes give war or dates of service)		<b>17. INFORMANT</b> Address <u>  </u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Atherosclerosis</u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>	<b>20f. (City or town)</b> (County) (State) <u>  </u>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12/1</u> <u>1960</u> <u>to</u> <u>6/10</u> <u>1961</u> <u>that (I) (we) last saw the deceased alive on</u> <u>6/6</u> <u>1961</u> , <u>and that death occurred at</u> <u>10:20 AM</u> , <u>from the causes and on the date stated above.</u>			
<b>22a. SIGNATURE</b> <u>Conrad L. Richter</u> M.D.		<b>22b. DATE SIGNED</b> <u>  </u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Conrad L. Richter</u>		<b>22d. ADDRESS</b> <u>3128 Harford Rd.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>6/13.61</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parkwood Cemetery</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, Maryland</u>
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>Leonard J. Ruck</u>		<b>25a. REC'D BY REGISTRAR</b> <u>  </u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>		<b>25c. DATE</b> <u>JUN 13 '61</u>	

VR A15 (4)  
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/59

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6516  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06500

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>-</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTO</i> <i>3V01-4</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Augsburg Home</i>		d. STREET ADDRESS <i>4213 CONNECTICUT Ave</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Sophia Fredericka LOTZ</i>		4. DATE OF DEATH Month Day Year <i>6 17 1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>APRIL 6, 1867</i>
9. AGE (In years lost birthday) <i>94</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>BALTO.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>John Dietrich</i>		14. MOTHER'S MAIDEN NAME <i>KATHERINE Rensch</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Augsburg Home Records</i>		Address <i>6811 Campfield Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Arterio-sclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Hemorrhage</i> DUE TO <i>-</i> (c) <i>-</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5-7 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized Arterio Sclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4/12</i> 19 <i>61</i> , to <i>6/17</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>6/16</i> 19 <i>61</i> , and that death occurred at <i>4 P.</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Earl L. Chambers</i>		22b. DATE SIGNED <i>6/19/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Earl L. Chambers</i>		22d. ADDRESS <i>4106 Liberty Hts Ave Balto-Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE THEREOF <i>6/20/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Landon Park</i>		23d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Hatt + Son</i>		24. ADDRESS <i>28</i>	
25a. REC'D BY REGISTRAR DATE <i>JUN 21 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6517 CERTIFICATE OF DEATH 06501											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN lb <b>33 Days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>				d. STREET ADDRESS <b>3722 - Sixth Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ALBERT</b>			First Middle Last <b>--- LOWMAN</b>			4. DATE OF DEATH <b>June 22 19 61</b>		Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 1, 1894</b>		9. AGE (In years last birthday) yrs. <b>66</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bag Printer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Fertilizer Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Asa Lowman</b>						14. MOTHER'S MAIDEN NAME <b>Margaret Rhoades</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>212-01-5352</b>		17. INFORMANT <b>Clinical Records, VA Hospital, Baltimore 18, Md. Fort Howard Division</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, TERMINAL</b>											
332X DUE TO											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.											
(b) <b>CEREBRAL THROMBOSIS, LEFT</b>											
(c) <b>CEREBRAL ARTERIOSCLEROSIS</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>ARTERIOSCLEROTIC HEART DISEASE - Duration Unknown</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (he) (this hospital) attended the deceased from <b>May 20, 1961</b> to <b>June 22, 1961</b> , that (he) (we) last saw the deceased alive on <b>June 22, 1961</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Thomas F. Crahan</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/22/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M. D.</b>						22d. ADDRESS <b>VAH, BALTIMORE 18, MARYLAND FORT HOWARD DIVISION</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6-26-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Anne Arundel County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James L. McCully</b>						ADDRESS <b>237 Patapsco Ave. Balto. 25, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 26 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

M

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James H. McGowan, 231 West 23rd Ave. New York 11, N.Y.  
Wm. J. McGowan, 231 West 23rd Ave. New York 11, N.Y.  
Wm. J. McGowan, 231 West 23rd Ave. New York 11, N.Y.

Wm. J. McGowan, 231 West 23rd Ave. New York 11, N.Y.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

6518

06502

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Balto</u> <span style="float:right">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12mo - 2d</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sheppard Pratt Hosp.</u>				d. STREET ADDRESS <u>4608 Roland Ave</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary</u> First <u>Susan</u> Middle <u>Lupton</u> Last				<b>4. DATE OF DEATH</b> <u>June 2</u> 19 <u>61</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 19 1865</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pub Sch.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp Records</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Term</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr. Bronch. Sinus L. &amp; Senile P. van Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 25</u> 19 <u>61</u> to <u>June 2</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>May 1</u> 19 <u>61</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>W. W. Elgin</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/2/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. W. Elgin</u>				22d. ADDRESS <u>Sheppard Pratt Hosp. Towson Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>6-3-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell &amp; Sons, Inc.</u> ADDRESS <u>1900 Eutaw Pl</u>				25a. REC'D BY REGISTRAR <u>JUN 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Kline</u>	

03205

CERTIFICATE OF DEATH

1919

(M)

CHIEF CLERK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6519

CERTIFICATE OF DEATH

Reg. Dist. No. 06503

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1607 Potomac Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ida M.</b> Middle <b>Lutz</b> Last <b>Lutz</b>				4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/17/1888</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>John L. Farley</b>				14. MOTHER'S MAIDEN NAME <b>Margrette ???</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>unknown</b>			
17. INFORMANT Address <b>Earl F. Lutz 1607 Potomac Ave. (son)</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio Vascular disease</b> 44 3X DUE TO (b) <b>Residual Hemiplegia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>							
20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 28</b> , 19 <b>61</b> , to <b>June 28</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>June 28</b> , 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Charles Tommasello</b> M.D. <b>C</b> PHYSICIAN'S NAME (Type) <b>Dr. C.J. Tommasello</b> <b>910 W. Lombard St.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
22b. DATE THEREOF <b>7/1/61</b>							
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>							
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Howard H. Hubbard 4107 Wilkens Ave.</b>							
24a. REC'D BY REGISTRAR DATE <b>JUL 3 '61</b>							
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>							

10303

CENTRAL BANK

1012

(M)

(1)

1000 Potomac Ave.

Edw. M. Linn

217-1888

H. Sewell

1000 Potomac Ave.

John A. Forster

1000 Potomac Ave.

Edw. M. Linn

*Handwritten notes and signatures, including "John A. Forster" and "Edw. M. Linn".*

1000 Potomac Ave.

Edw. M. Linn

1000 Potomac Ave.

1000 Potomac Ave.

1000 Potomac Ave.

CERTIFICATE OF DEATH

Reg. Dist. No.

06504

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1918 Gettysburg Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nicholas</u> First <u>Mabe</u> Middle <u>Mabe</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-23-1890</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>George Mabe</u>	
14. MOTHER'S MAIDEN NAME <u>Rose</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Jessie L Anderson</u> Address <u>1918 Altamere Rd - 28</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>181.0</u> DUE TO <u>Carcinoma of Bladder (Urinary) with Metastases to Inguinal glands Bilat.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 60</u> to <u>6/18/61</u> , that I last saw the deceased alive on <u>6/16/61</u> , 19 <u>61</u> , and that death occurred at <u>300A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. McGrath</u> M.D.		ADDRESS (Street, city or town, state) <u>1303 Frederick Rd</u> DATE SIGNED <u>6/18/61</u>	
PHYSICIAN'S NAME (Type) <u>W. E. McGrath</u>		<u>Catonsville 28 md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-21-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Max Anderson</u> ADDRESS <u>Catonsville - 28</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 22 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
FOR STATE  
HEALTH DEPT.

TO: DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please, execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

6521  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06505

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson c. LENGTH OF STAY IN 1b 2 hrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13, Maryland d. STREET ADDRESS 3618 Bonview Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Richard R. MacCubbin		4. DATE OF DEATH Month 6 Day 9 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Elevator Opr.		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland - Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Maccubbin		14. MOTHER'S MAIDEN NAME Cora Palmer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown no		16. SOCIAL SECURITY NO. 216 219-09-0298	
17. INFORMANT Medical records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Pulmonary Tbc.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>None</u> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>None</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>6 mo.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <u>E. A. Caples</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/61	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		22d. LOCATION (City, town, or country) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR Charles E. Schimunek Funeral Home 3331 Brehms Lane		24a. REC'D BY REGISTRAR DATE JUN 13 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Frank		DATE SIGNED 6-9-61	

MEDICAL CERTIFICATION

00502

WESTLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6522

06506

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BLADENSBURG</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE HOSPITAL</b>		d. STREET ADDRESS <b>5220 TILDEN RD.</b>	
3. NAME OF DECEASED (Type or print) <b>MAGUIRE, RALPH</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-21-06</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days <b>24</b> <b>19</b> <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER - DECORATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>FRANCIS MAGUIRE</b>		14. MOTHER'S MAIDEN NAME <b>THAIDER MAGUIRE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>RECORDS: SPRING GROVE STATE HOSP</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> 4201 DUE TO <b>Coronary thrombosis 4.1.1961</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Chronic cardio-vascular disease</b> (c) <b>embolism.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 6<sup>th</sup> 1961</b> , to <b>June 27<sup>th</sup> 1961</b> , that (I) (we) last saw the deceased alive on <b>6.24.1961</b> , and that death occurred at <b>7:30 A.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Gertrude J. Fleischmann</b>		22b. DATE SIGNED <b>6.26.1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>GERTRUDE J. FLEISCHMANN</b>		22d. ADDRESS <b>Spring Grove State Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/28/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington D C</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 28 '61</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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CHERRY, LEE

SPRING CREEK, WISCONSIN

MARQUINE, ALICE

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PRINTER - RECORDS

RECORDS MANAGER

YES

THOMAS MARQUINE

RECORDS 2500 AND 2 2000 1000

L. GARCIA'S HOME, WYOMING, WY.

0123/01

W. Oliver Cemetery

Washington D.C.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 3280 6/28/61 iwk

## CERTIFICATE OF DEATH

Reg. Dist. No.

06507

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>122 Sallers Pt. Rd.</u>		d. STREET ADDRESS <u>120 Sallers Pt. Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Sarah Elizabeth Malone</u>		4. DATE OF DEATH <u>June 17</u> 19 <u>61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 27/1894</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>17</u> Hours <u>12</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown Louis Coleman</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Mary?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>213-264846</u>	
17. INFORMANT <u>Hugh P. Henneberry, Rev.</u>		Address <u>140 Oak Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease (Infarct)</u> 24 hrs 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Disease</u> 10 yrs DUE TO (c) <u>Disease: Arterio-Sclerosis</u> 12 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 16</u> , 19 <u>61</u> , to <u>June 17</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>June 17</u> , 19 <u>61</u> , and that death occurred at <u>140 Oak Ave</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Wado</u>		DATE SIGNED <u>6-17-61</u>	
PHYSICIAN'S NAME (Type) <u>William C. Wado M.D.</u>		<u>Dundalk Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>June 21, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Catholic Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs Walter R. Williams</u>		ADDRESS <u>322 N. Phoenix St. Baltimore, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUN 22 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is divided into several horizontal sections with labels for each field.

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

LOCATION: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Registrar's Signature: \_\_\_\_\_

Official Seal: \_\_\_\_\_





VS A15 (4)  
15M 9/58

6508

CERTIFICATE OF DEATH

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
06509									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>-</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>					c. LENGTH OF STAY IN 1b <b>17yr6mthl1dys</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>					d. STREET ADDRESS <b>3515 Hickory Avenue</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>S.</b> Last <b>Marsh</b>					4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 61</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 15, 1900</b>		9. AGE (In years last birthday) <b>60</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Standard Brands</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Isaca Marsh</b>					14. MOTHER'S MAIDEN NAME <b>Ida Jackson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b>212-09-2708</b>				
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic cardiovascular disease</b> (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>June 5, 1961</b> , to <b>June 26, 1961</b> that (I) (we) last saw the deceased alive on <b>June 26, 1961</b> , and that death occurred at <b>3:40 p.m.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Stella Wachsler</b>					22b. DATE SIGNED <b>6-26-61</b>				
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>					22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>6/30/61</b>				
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>					23d. LOCATION (City, town or county) (State) <b>Balto Co.</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Paul E. Chmowetz Jr.</b>					25a. REC'D BY REGISTRAR <b>JUN 30 61</b>				
ADDRESS <b>3617 Chestnut Ave</b>					25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>				

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12/10/61 12/10/61 12/10/61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

6526

06510

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>82 Days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
f. STREET ADDRESS <b>2543 McCulloh Street</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CYRUS W. MARSHALL, Sr.</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>10</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/27/91</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>10</b> Hours <b>19</b> Min.		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>			
13. FATHER'S NAME <b>Thorney G. Marshall</b>				14. MOTHER'S MAIDEN NAME <b>Annie E. Robinson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>215-14-3039</b>			
17. INFORMANT <b>WW I</b>				Address <b>Clin. Rec. VAH, Balto. Md. Ft. Howard Division</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY ARTERY DISEASE</b>							
DUE TO (b) <b>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</b>							
(c) <b>MALNUTRITION</b>							
(d) <b>CARCINOMA OF RECTUM WITH METASTASIS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <b>March 20, 1961</b> , to <b>June 10, 1961</b> , that (2) (we) last saw the deceased alive on <b>June 10, 1961</b> , and that death occurred at <b>2:00PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>OTTO C. BEYER, M.D.</b>				22b. DATE SIGNED <b>6/10/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>OTTO C. BEYER, M.D.</b>				22d. ADDRESS <b>VAH, BALTO. MD. FORT HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 14, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>				25a. REC'D BY REGISTRAR <b>JUN 15 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>							

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03218

(M)

Bellevue

Bellevue

Bellevue

82 Days

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Bellevue Administration Building

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Bellevue, W.V.

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U.S.A.

Bellevue, West Virginia

Bellevue City

Teacher

Thomas G. Harrell

Anna E. Robinson

SIR: In 1909, John W. Harrell, W.V., moved to

Yon

CONGRATULATE

WITH SPECIALTY CARD VASQUEZ

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W.V. HARRELL, JR. FORT HARRIS DIVISION

W.V. HARRELL, JR.

Bellevue, West Virginia

June 11, 1901

Bellevue

W.V. HARRELL, JR.

Bellevue, W.V.



Reg. Dist. No. 06511

FOR STATE  
HEALTH DEPT.

M

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I

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere (19)</b>		c. LENGTH OF STAY IN 1b <b>1 yr.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., 2402 Manning Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RALPH</b> Middle <b>H</b> Last <b>MARSHALL</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>13</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb-19-1910</b>
9. AGE (In years last birthday) <b>51 yrs.</b>		10. IF UNDER 1 YEAR Months <b>51</b> Days <b>13</b> Hours <b>19</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Checker &amp; Receiver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Arcrods Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Sadie Lehr</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>203-01-7042</b>	
17. INFORMANT <b>Mrs. Janet Marshall</b>		Address <b># 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Hour <b>a. m. p. m.</b> Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M B Davis</b>		DATE SIGNED <b>6/14/61</b>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-16-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN J. DUDA</b>		24a. REC'D BY REGISTRAR <b>OWN 19'61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knecht</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

6528

06512

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>9 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Eugene</b> Middle <b>Fulton</b> Last <b>Martin</b>				4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>1961</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 24, 1884</b>		9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months <b>77</b> Days <b>14</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>groom</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>riding stable</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>August Martin</b>				14. MOTHER'S MAIDEN NAME <b>unknown Jane Anderson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>2-13-38-7331</b>		17. INFORMANT <b>Mrs. Angela Meise</b> Address: <b>SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>782.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Harford</b>	(County) <b>Harford</b>	(State) <b>Maryland</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>June 5, 1961</b> to <b>June 14, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 14, 1961</b> , and that death occurred at <b>8:40</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Loretta Hsu</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED <b>6-14-61</b>				
22c. PHYSICIAN'S NAME (Type) <b>Loretta Hsu, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 17, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Friendship Methodist</b>	23d. LOCATION (City, town, or county) <b>Fallston</b>	(State) <b>md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Archer</b>		ADDRESS <b>Benson</b>	25a. REC'D BY REGISTRAR DATE <b>JUN 19 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur L. Farris</b>			

924-6733

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CERTIFICATE OF DEATH

1900

(M)

CHIEF CLERK

W. A. DAVIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD  
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6529

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06513

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		d. STREET ADDRESS <u>116 N. SYMINGTON AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>116 N. SYMINGTON AVE</u>				d. STREET ADDRESS <u>116 N. SYMINGTON AVE</u>					
3. NAME OF DECEASED (Type or print) <u>MAMIE</u>		First Middle Last <u>H. MATHEWS</u>		4. DATE OF DEATH <u>JUNE 4 1961</u>		Month Day Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 15, 1878</u>		9. AGE (In years last birthday) <u>83</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>William Renicke</u>				14. MOTHER'S MAIDEN NAME <u>JORDAN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Mr. Marie Jarboe - 116 N. Symington Ave.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Arteriosclerotic CVD</u>				INTERVAL BETWEEN ONSET AND DEATH <u>One hour</u> <u>One hour</u> <u>Unknown</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>January 1959</u> to <u>June 4, 1961</u> , that (I) <u>did</u> last saw the deceased alive on <u>June 1, 1961</u> , and that death occurred <u>at 5 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>James Nolan</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>L. J. NOLAN</u>				22d. ADDRESS <u>Baltimore 29, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-7-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frederic Cavanaugh F. H. Catonsville, Md.</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE <u>JUN 8 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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1878

George Thompson  
George Thompson  
George Thompson

James

James  
James

Baltimore



## CERTIFICATE OF DEATH

Reg. Dist. No. 06514

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>English Counsel</u>		c. LENGTH OF STAY IN 1b <u>English Counsel 27</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2723 Arbutus Ave</u>		d. STREET ADDRESS <u>2723 Arbutus Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edward L. Matthews</u>		4. DATE OF DEATH <u>JUNE 14 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7 DEC 1905</u>
9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>IRON WORKER (RET)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jeremiah Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Lottie Price</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>41-705-0851</u>	
17. INFORMANT <u>Gloria P. Conn</u>		Address <u>317 Hance Ave Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO <u>Hypertensive Arteriosclerotic C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>3 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<u>Rheumatic C.V.D. - Carcinoma of Larynx</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-2-45</u> , 19 <u>45</u> , to <u>6.14.61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>May 1</u> , 19 <u>61</u> , and that death occurred at <u>??</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Nathan Raousin</u>		ADDRESS (Street, city or town, state) <u>206 S. Gilmer St. Baltimore Md</u>	
DATE SIGNED <u>6.14.61</u>			
PHYSICIAN'S NAME (Type) <u>NATHAN RAOUSIN MD</u> <u>Balto 23 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>12 June 1961</u>	<u>Woodson Park Cem</u>	<u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Knapp</u>		ADDRESS <u>Arthur S. Knapp</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>JUN 16 '61</u>		<u>Arthur S. Knapp</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of the deceased: [illegible]  
2. Age: [illegible]  
3. Sex: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of the physician: [illegible]  
9. Signature of the registrar: [illegible]  
10. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

6531

06515

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Ind</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Summit Nursing Home</u>				d. STREET ADDRESS <u>772 W. Hamburg St.</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen A</u> Middle <u>McGiff</u> Last <u>McGiff</u>		4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>7</u> Day <u>12</u> Year <u>1881</u>		9. AGE (In years last birthday) Yrs. <u>79</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mr Edward J. McGiff</u>		Address <u>Same</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure Acute &amp; chronic</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Degenerative Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>6/12/61</u>		20f. (City or town) (County) (State) <u>6/14/61</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6/13/61</u> to <u>6/14/61</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>6/13/61</u> , and that death occurred <u>1207p</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W.E. McGrath</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/14/61</u>		22d. ADDRESS <u>1303 Frederick Rd Catonsville 28 Md</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.E. McGrath M.D.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/17/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Washington Rd Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowanssion</u>		ADDRESS <u>22 Collins St.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 16 61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

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VS. A15ME  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
6532 06516											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point, Md.</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-24</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethlehem Steel Co. Dispensary</b>						d. STREET ADDRESS <b>3004 Beverly Rd.</b>					
3. NAME OF DECEASED (Type or print) <b>Ernest Lambert Meisel</b>						4. DATE OF DEATH <b>6 - 5 - 1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-23-1903</b>		9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank N. Meisel</b>						14. MOTHER'S MAIDEN NAME <b>Katherine E. Booker</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>						16. SOCIAL SECURITY NO. <b>217-09-9475</b>		17. INFORMANT <b>Mrs John Abbott 5507 Sefton Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO <b>hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>4 yrs</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Jack E Collins</b>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Jack E Collins</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county) <b>6-5-61</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				22b. DATE THEREOF <b>6-8-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery Baltimore, Md.</b>				22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <b>Leonard J. Ruck 5305 Harford Rd.</b>						24a. REC'D BY REGISTRAR DATE <b>JUN 7 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

00216





6533  
Baltimore County

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

06517

1. PLACE OF DEATH a. COUNTY <b>CATONSVILLE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1222-Ingwell Drive</b> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>BALTIMORE</b> b. COUNTY <b>MARYLAND</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>2828 Ashland Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Joseph's Nursing Home</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <b>2828 Ashland Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth First Matejka Middle Michael Last</b> <b>Elizabeth (Matejka) Michael</b>		4. DATE OF DEATH Month <b>6</b> Day <b>22</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-18-1883</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>CZECHOSLOVAKIA</b> <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH STREJCZEK</b> <b>Joseph Strejczek</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE PIETRIK</b> <b>Catherine Pietrik</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>215-05-4475</b>	
17. INFORMANT <b>Alfred Michael - Son</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>20 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/28/61</b> 19____, to <b>6/22/61</b> 19____, that (I) (we) last saw the deceased alive on <b>6/22/61</b> 19____, and that death occurred at <b>5 pm</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>J. E. Rowe</b>		22b. DATE SIGNED <b>6/22/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>James E. Rowe</b>		22d. ADDRESS <b>1011 Frederick Rd. 28-Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>6-26-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>1404 B. Deemer</b>	23d. LOCATION (City, town, or county) (State) <b>Balto-Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Czech Funeral Home, Inc. E. S. Czech</b>		25a. REC'D BY REGISTRAR <b>JUN 27 '61</b>	
ADDRESS <b>1404 B. Deemer</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

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COPIED  
HARVARD

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL

(M)

IN SENATE  
January 10, 1907  
REPORT OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
MAY 1, 1906

ALBANY:  
J.B. LIPPINCOTT & CO. PRINTERS  
1907

(I)

THE LAND OFFICE  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
6534 CERTIFICATE OF DEATH 06518												
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore County</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Shady Nook Nursing Home 1002 N. Rolling Rd. Formerly of 3800 Callaway Ave.</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>Shady Nook Nursing Home 1002 N. Rolling Rd. Formerly of 3800 Callaway Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Elsie B. Mitchell</b>			4. DATE OF DEATH <b>June 25 1961</b>			9. AGE (In years last birthday) <b>78</b> yrs.			IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 9, 1882</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				13. FATHER'S NAME <b>Millard Burrier</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>				17. INFORMANT <b>Mr. F. Ward Mitchell Jr. 733 Whitehall Rd.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X</b> <b>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE -</b> DUE TO <b>CEREBRAL THROMBOSIS -</b> DUE TO <b>DIA BETES MELLITUS</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <b>11/1</b> 19 <b>58</b> to <b>6/25</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>6/25</b> 19 <b>61</b> , and that death occurred at <b>6:10 PM</b> from the causes and on the date stated above.												
22a. SIGNATURE <b>John H. Shaw M.D.</b>						22b. DATE SIGNED <b>6/26/61</b>						
22c. PHYSICIAN'S NAME (Type) <b>John H. Shaw M.D.</b>						22d. ADDRESS <b>5800 EDWINA AVE BALTIMORE MD</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-28-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>						
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Zickner &amp; Son Inc. North La. Bldg.</b>						25a. REC'D BY REGISTRAR <b>17</b>		25b. REGISTRAR'S SIGNATURE <b>James L. Thomas</b>				
DATE <b>JUN 27 '61</b>												

10012

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Mr. E. E. Smith, 10012

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<b>MARYLAND STATE DEPARTMENT OF HEALTH</b>			
<b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>			
<b>CERTIFICATE OF DEATH</b>		<b>06519</b>	
6535			
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>103 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>535 Hampton Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGE W. MURRAY, SR.</b>		4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1897</b>
9. AGE (In years last birthday) <b>63 yrs.</b>		10. IF UNDER 1 YEAR Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min. <b>63</b>	11. IF UNDER 24 HRS. Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min. <b>63</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Caretaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Texas, Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Murray</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Parks</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>216-05-6998</b>	
17. INFORMANT <b>CLINICAL RECORDS, VAH, BALTIMORE, MD.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ANAPLASTIC CARCINOMA OF RIGHT BRONCHUS</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>162-1</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>W</b> (this hospital) attended the deceased from <b>February 20, 1961</b> to <b>June 3, 1961</b> that <b>(X)</b> (we) last saw the deceased alive on <b>June 3, 1961</b> , and that death occurred at <b>1:24 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Norman P. Jones, M.D.</b>		22b. DATE SIGNED <b>6/3/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>NORMAN P. JONES, M. D.</b>		22d. ADDRESS <b>VAH, BALTO. MD. FT HOWARD DIV.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-6-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>2901 Taylor Ave. Balto 14, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight Funeral Home, 6009 Harford Rd. Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 7 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

VR A15 (4)  
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> c. LENGTH OF STAY IN lb <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fowler Conu. Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>5400 Lynview Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>SARAH</u>		First <u>7</u> Middle <u>Myers</u> Last <u>Myers</u>		4. DATE OF DEATH <u>June 2 1961</u>		Month <u>June</u> Day <u>2</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1883</u>		9. AGE (In years last birthday) <u>77 1/2</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Not Known</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>Harvey Myers -624 40460000</u>		17. INFORMANT <u>Harvey Myers -624 40460000</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral + Coronary arteriosclerosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Diabetes Mellitus</u> (c) <u>Diabetes Mellitus</u> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/1/61</u> to <u>6/2/61</u> , that (I) (we) last saw the deceased alive on <u>6/1/61</u> , 19 <u>1945</u> , and that death occurred at <u>6A</u> M., from the causes and on the date stated above.									
22a. SIGNATURE <u>Melvin Skins</u>				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/2/61</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>2320 Eutaw Place</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>6-2-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>		23d. LOCATION (City, town or county) <u>Balto</u>		(State) <u>Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>				ADDRESS <u>2000 Eutaw Place</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

(M)

(1)

Female white  
Hairy wings  
Red brown

Small

Highly common

Common

Red brown

Red brown  
Hairy wings  
Red brown

Small

Highly common

Common

Red brown

Very large  
Common  
Red brown  
Hairy wings  
Red brown  
Small  
Highly common  
Common  
Red brown

00000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6537

06521

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>405 Dixie Drive</u>		d. STREET ADDRESS <u>405 Dixie Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>E. Mamee</u> <u>Mamee</u> <u>Nied</u>		4. DATE OF DEATH Month Day Year <u>6</u> <u>17</u> <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-1884</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. AGE (In years last birthday) <u>76</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John T. Bevan</u>	
14. MOTHER'S MAIDEN NAME <u>Mary R.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. <u>Harry B. Nied</u>		17. INFORMANT <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial degeneration</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u> (e), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1936</u> to <u>June 17, 1961</u> , that (I) <u>(no)</u> last saw the deceased alive on <u>6-16</u> 19 <u>61</u> , and that death occurred at <u>9:45</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>John J. Gould</u>		22b. DATE SIGNED <u>6-17-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN J. GOULD</u>		22d. ADDRESS <u>147 East Ave - 2F</u>	
23b. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23c. DATE THEREOF <u>6-20-1961</u>	
23d. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23e. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25. REC'D BY REGISTRAR DATE <u>JUN 20 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

(M)

(1)

London, N. York 2302  
London, N. York 2302

London, N. York 2302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1

6538

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06522

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN lb <i>5 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shady Hook Home</i>		d. STREET ADDRESS <i>Cherrydale Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Katherine</i> Middle <i>Marie</i> Last <i>Opel</i>		4. DATE OF DEATH Month <i>6</i> Day <i>17</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-12-1875</i>
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>August Opel</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Klein</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Medred E. Smith - White Marsh - Md</i>		Address.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Ischemic</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary sclerosis</i> DUE TO (c) <i>Generalized arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1-2 wks.</i> <i>1037.</i> <i>1037.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10-16</i> 19 <i>60</i> to <i>6-17</i> 19 <i>61</i> , that (I) ( <i>we</i> ) last saw the deceased alive on <i>6-17</i> 19 <i>61</i> , and that death occurred at <i>7:15 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Wilmer K. Gallagher</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher</i>		22d. ADDRESS <i>6309 Frederick Rd, Baltimore, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6-20-1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Landon Park</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Edw. J. [Signature]</i>		25a. REC'D BY REGISTRAR <i>JUN 21 1961</i>	
ADDRESS <i>Catonsville - 78 - Md</i>		25b. REGISTRAR'S SIGNATURE <i>John S. [Signature]</i>	

00252

CERTIFICATE OF DEATH

(M)

(1)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>22 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Queen Annes</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Centreville</b> d. STREET ADDRESS <b>--</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>WALTON</b>			First Middle Last <b>C. ORRELL</b>			4. DATE OF DEATH <b>June 6 19 61</b>		Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>October 26, 1889</b>		9. AGE (In years last birthday) <b>71</b> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tax-Collector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INCOME TAX</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Chestertown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
13. FATHER'S NAME <b>W. C. Orrell</b>					14. MOTHER'S MAIDEN NAME <b>Cora Story</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW I</b>					16. SOCIAL SECURITY NO. <b>214-03-3917</b>					17. INFORMANT <b>Clinical Records, VAH, Baltimore, Maryland</b> <b>Fort Howard Division</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>420.0</b> DUE TO <b>MYOCARDIAL INFARCT</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Edema. Tumor, left lung.</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 MIN.</b> <b>RECENT UNKNOWN</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that <b>W</b> (this hospital) attended the deceased from <b>May 15, 1961</b> to <b>June 6, 1961</b> , that <b>W</b> (we) last saw the deceased alive on <b>June 6, 1961</b> , and that death occurred at <b>8:15 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Thomas F. Crahan</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE <b>6/9/61</b>				
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>					22d. ADDRESS <b>VAH, BALTO 18 MD, FT. HOWARD DIVISION</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>JUNE 9-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Memorial</b>		23d. LOCATION (City, town or county) (State) <b>Route 55 n. Easton Maryland</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard Butler of Butler Bros</b>					ADDRESS <b>Centreville Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 13 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

M

I

66553

6738

M

Green Avenue

Highland

Belmont

Conoverville

22 Days

Port Howard

Voluntary Admission to Hospital

CHIEF

WILSON

Male

White

October 28, 1935

U. S. A.

Chocoma, Michigan

White 7-4

Tex. College

M. C. O'Neil

Core Henry

Clinical Records, Van Buren, Michigan  
Port Howard Division

2-4-01-301

W-1

Yes

CARDIO ARREST

MYOGENIC EFFECT

ARTIFICIALLY INDUCED

3 MIN.  
RECORD  
CHIEF

Voluntary Admission, Port Howard

May 12, 1935

01

June 3

67701

VAN BUREN IS NO. 17. REMAINS DIVISION

THOMAS E. CHAPMAN, M.D.

During the 4-year clinical observation, there was no further hospitalization. The patient was discharged on June 3, 1935.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6540 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06524											
Item 22 Film G290 7/17/61 iwk											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> c. LENGTH OF STAY IN 1b <b>15 min.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6 Hanover Road</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>2 Westmoreland Street</b> d. STREET ADDRESS <b>Westminster</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>RALPH STERLING OSTERHUS</b>					4. DATE OF DEATH <b>June 23 1961</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 15, 1916</b>		9. AGE (In years last birthday) <b>45</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>F2H</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Congoleum Nairn Inc</b>			11. BIRTHPLACE (State or foreign country) <b>Carroll County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Osterhus</b>					14. MOTHER'S MAIDEN NAME <b>Grace Gallaway</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give year or dates of service) <b>WW II</b>					16. SOCIAL SECURITY NO. <b>217-03-4541</b>		17. INFORMANT <b>Congoleum Nairn Inc. Records-</b>			Address <b>Cedarhurst, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b> INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>none</b> p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE <b>D. D. Caples</b>					DATE SIGNED <b>6-23-61</b>						
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>					Address (State, city, town, or county) <b>6 Hanover Rd. Reisterstown, Md.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 26, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Carrollton Church of God</b>		22d. LOCATION (City, town, or country) (State) <b>Rural-Westminster, Md.</b>					
23. FUNERAL DIRECTOR <b>Myers Funeral Home, Willis St. &amp; Longwell Ave</b>					24a. REC'D BY REGISTRAR <b>JUN 29 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>						
Westminster, Md.											



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6541

06525

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> c. LENGTH OF STAY IN 1b <b>6 Yr.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>107 LOCUST DR.</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> d. STREET ADDRESS <b>107 LOCUST DR.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>DOUGLAS S. OTTERSON</b>				4. DATE OF DEATH <b>6/8/1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/14/04</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>6</b> Hours <b>1</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman Tool Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>N.Y. N.Y.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WM. C. OTTERSON</b>		14. MOTHER'S MAIDEN NAME <b>DUMAS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mrs. Paige Ottersen</b> Address <b>no</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INSUFFICIENCY</b> <b>443 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular Disease</b> (c) <b>Arteriosclerotic Vascular Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs 2 months</b> <b>at least 5 years</b> <b>7 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC ASTHMATIC BRONCHITIS</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JAN. 23, 1956</b> , to <b>June 8, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 1, 1961</b> , and that death occurred at <b>7:20 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Melvin N Borden</b> M.D.				22b. DATE SIGNED <b>6/9/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Melvin N. BORDEN</b>				22d. ADDRESS <b>5000 Balto. NATIONAL PIKE BALTO 29 MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		23b. DATE THEREOF <b>6/10/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Towson Park</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James Haff &amp; Son 28</b> ADDRESS <b>12 '61</b>				25a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

(J)

15523



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

M

I

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
6542 CERTIFICATE OF DEATH 06526														
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>1 mth 26dys</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>30 South Pulaski Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Pall</b> Last <b>Pall</b>					4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1961</b>									
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1901, March 3</b>		9. AGE (In years last birthday) <b>60 yrs.</b> IF UNDER 1 YEAR: Months <b>60</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>miner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>construction</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Russia</b>						
13. FATHER'S NAME <b>unknown</b>					14. MOTHER'S MAIDEN NAME <b>unknown</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>					16. SOCIAL SECURITY NO. <b>196-01-8400</b>					17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b> Address <b>Interval BETWEEN ONSET AND DEATH</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>422.1</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>disease</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour <b>9</b> a.m. <b>19</b> p.m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) <b>Baltimore</b>					20g. (County) <b>Md.</b>					20h. (State) <b>Md.</b>				
21. I certify that (I) (this hospital) attended the deceased from <b>June 8, 1961</b> , to <b>June 20, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 20, 1961</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>Jose R. Arizaga</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <b>June 20, 1961</b>				
22c. PHYSICIAN'S NAME (Type) <b>JOSE R. ARIZAGA, M.D.</b>					22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL</b> <b>Catonsville 28, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>6-23-61</b>					23c. NAME OF CEMETERY OR CREMATORY <b>London Park</b>				
23d. LOCATION (City, town or county) <b>Baltimore</b>					23e. (State) <b>Md.</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frederick R. ...</b>					24a. ADDRESS <b>2101 Frederick Rd.</b>					25. REC'D BY REGISTRAR <b>JUN 22 '61</b>				
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>					24c. (State) <b>Md.</b>									

1300

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June 20 1951

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1951-06-20

Wounded

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Wounded

Wounded

June 21 1951

88

June 21 1951

June 21 1951

June 21 1951

June 21 1951

## CERTIFICATE OF DEATH

Reg. Dist. No.

06527

6543

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville, 28</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville, 28</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6103 Frederick Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bennett Brown Parks</u> Middle Last		4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>19 61</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/8/05</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Customs</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edgar Parks</u>		14. MOTHER'S MAIDEN NAME <u>Irene Schinberg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W.II</u>		16. SOCIAL SECURITY NO. <u>? 216-10-8788</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crownary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>733</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-11-1952</u> to <u>6-16-1961</u> , that I last saw the deceased alive on <u>6-16-1961</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>6209 Frederick Ave. Baltimore, Md. 6-16-61</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		<u>Baltimore-28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>6/20/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 21 '61</u>	
ADDRESS <u>Ellicott City, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1953

CERTIFICATE OF DEATH

(M)

(1)

1  
FOR STATE  
HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

6544

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06528

1. PLACE OF DEATH e. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7 WILLOW AVE</b>				d. STREET ADDRESS <b>7 WILLOW AVE</b>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>HERBERT</b> Last <b>PETERSON</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>26</b> Year <b>1961</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-30-04</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b>		IF UNDER 24 HRS. Hours <b>5</b> Min. <b>5</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postal Deliveryman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>							
13. FATHER'S NAME <b>John Thomas Peterson</b>				14. MOTHER'S MAIDEN NAME <b>Mary Florence Torbit</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>125-42-5962</b>		17. INFORMANT <b>Family Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GUNSHOT WOUND, CALVARIUM</b> <b>976X</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>MENTAL DEPRESSION</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>William A. Pillsbury</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Towson, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 30, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		22d. LOCATION (City, town, or country) (State) <b>Parkville, Maryland</b>	
23. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 5 '61</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Klaus</b>	

MEDICAL CERTIFICATION



Postal Deliveryman

U.S. Post Office

Maryland

USA

John Thomas Peterson

Mary Florence Toroit

Box

125-42-7062

Family Records

Postal June 30, 1961 Maryland Memorial Park

John Thomas, Toroit, Maryland



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6545

06529

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Overlea)</b> c. LENGTH OF STAY IN 1b <b>(Overlea)</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>10 Fullerton Heights Avenue</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Baltimore</b> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Overlea)</b> h. STREET ADDRESS <b>10 Fullerton Heights Avenue</b> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>Edgar Clayton Philipp</b>		4. DATE OF DEATH Month Day Year <b>June 19, 1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 19, 1887</b>		9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Henry Philipp</b>						14. MOTHER'S MAIDEN NAME <b>Katherine Lentz</b>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>213-10-7091</b>				17. INFORMANT <b>Mrs. Edgar C. Philipp-10 Fullerton Hts. Ave.</b>				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis &amp; infarction</b> DUE TO (b) <b>arteriosclerotic fibrosis</b> DUE TO (c) <b>Ch. congestive heart failure</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>4341</b>												INTERVAL BETWEEN ONSET AND DEATH <b>7-2-51</b> <b>1 year</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Towson</b>		(County) <b>Baltimore</b>		(State) <b>Md.</b>							
21. I certify that (I) (this hospital) attended the deceased from <b>7-2-1961</b> to <b>June 19, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 19, 1961</b> , and that death occurred at <b>9:05</b> M, from the causes and on the date stated above.																			
22a. SIGNATURE <b>GEO. McLEAN</b>												22b. DATE SIGNED <b>June 19, 1961</b>							
22c. PHYSICIAN'S NAME (Type) <b>GEO. McLEAN</b>												22d. ADDRESS <b>705 Med Arts Bldg - 1 - Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>				23b. DATE THEREOF <b>6-23-61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Towson, Maryland</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Tuckner Sons</b>												25a. REC'D BY REGISTRAR <b>JUN 21 '61</b>				25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00333

1333

(M)

(I)

TO THE DIRECTOR, FBI  
FROM THE DIRECTOR, FBI  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report with several paragraphs of text that is mostly illegible due to the quality of the scan.]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06530

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Eccleston</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Eccleston</i> X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Burnside Farms</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <i>Edwin Wingate Poe</i>		4. DATE OF DEATH <i>June 22 1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 13, 1876</i>
9. AGE (In years last birthday) <i>84</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Banker</i>	11. BIRTHPLACE (State or foreign country) <i>Louisville, Ky.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		13. FATHER'S NAME <i>Robert Poe</i>	
14. MOTHER'S MAIDEN NAME <i>Sallie Graham Wingate</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	
16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Mrs Miniam Poe Baetjer Owings Mills, Md.</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic heart disease</i> DUE TO (c) <i>15 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <i>1952</i> to <i>June 22, 1961</i> , that I lost sow the deceased alive on <i>22 June 1961</i> , and that death occurred at <i>2 PM</i> , from the causes and an the date stated above.	
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ACTUAL SIGNATURE <i>Paul H Royse</i> M.D. <i>1403 FOLEY LANE June 22, 1961</i>		ADDRESS (Street, city or town, state) <i>Pikesville 8 Maryland</i>	
PHYSICIAN'S NAME (Type) <i>PAUL H ROYSE</i>		DATE <i>JUN 26 '61</i>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation June 22, 1961</i>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <i>Greenmount Crematory</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkinst Sons Co. 4905 York Road</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

24a. REC'D BY REGISTRAR <i>JUN 26 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1870

CERTIFICATE OF DEATH

1870

(M)

Edwin Thompson  
Edwin Thompson  
Edwin Thompson

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FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6547

06531

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Parkville</b> c. LENGTH OF STAY IN <b>MD</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7806 Ardmore Avenue</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Parkville</b> d. STREET ADDRESS <b>7806 Ardmore Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>EUGENE</b> Last <b>POLANCO</b>				4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-18-1896</b>	
9. AGE (in years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>19</b>		IF UNDER 24 HRS. Hours <b>19</b> Min. <b>61</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dentist</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Dominican Republic</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Eugene Polanco</b>			
14. MOTHER'S MAIDEN NAME <b>Aurelia Payan</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>220-07-1465</b>				17. INFORMANT <b>Mrs. Mary C. Polanco</b> Address <b>same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease.</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>420.0</b> (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>420.0</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b> DATE SIGNED <b>6/3/61</b> Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>6/6/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR <b>Leonard J. Ruck</b> ADDRESS <b>5305 Harford Road.</b>				24a. REC'D BY REGISTRAR <b>JUN 5 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Charles S. Petty</b>			

IN THE COURT OF THE DISTRICT OF COLUMBIA



IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Court at Washington, D.C., this 1st day of January, 1911.

CLERK OF THE COURT

1911



## CERTIFICATE OF DEATH

Reg. Dist. No.

06532

6543

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stevenson</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hillside ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Alexander Hamilton E. Post</i>		4. DATE OF DEATH <i>June 5 1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 6, 1870</i>
9. AGE (In years last birthday) <i>90</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>President</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Merchandise - Safe Deposit and Trust Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Stevenson, Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Richard Bayley Post</i>		14. MOTHER'S MAIDEN NAME <i>Ella Stump</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>212-16-3125</i>	
17. INFORMANT <i>Address Butler Road</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident with left hemiplegia</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1958</i> to <i>5 June 1961</i> , that I last saw the deceased alive on <i>5 June 1961</i> , and that death occurred at <i>11 A. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Paul H. Royse</i>		ADDRESS (Street, city or town, state) <i>1403 Foley Lane</i>	
PHYSICIAN'S NAME (Type) <i>Paul H. Royse</i>		DATE SIGNED <i>5 June 61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial June 7, 1961</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>St Thomas Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Garrison Forest Balt. Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins &amp; Sons Co.</i>		ADDRESS <i>4905 York Road</i>	
24a. REC'D BY REGISTRAR <i>ANN 7 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. S. Thoma</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CENTRIC ARE OF HEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6549

## CERTIFICATE OF DEATH

Reg. Dist. No. 06533

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6919 Ridgeway Road</b>		d. STREET ADDRESS <b>6919 Ridgeway Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>HENRY WILLIAM POWELL</b>		4. DATE OF DEATH Month Day Year <b>June 30th, 19 61</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1898</b>
9. AGE (In years last birthday) yrs. <b>63</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Powell</b>		14. MOTHER'S MAIDEN NAME <b>Bette Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-07-7234</b>	
17. INFORMANT <b>Pansy B. Powell</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular de</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>10 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1</b> <b>19 52</b> , to <b>6 - 30</b> , <b>19 61</b> , that I last saw the deceased alive on <b>6 - 25</b> , <b>19 61</b> , and that death occurred at <b>8:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>2 Kinship Road</b> <b>7/3/61</b> ACTUAL SIGNATURE <b>Jack C. Collins</b> M.D. PHYSICIAN'S NAME (Type) <b>Jack C. Collins, M.D.</b> <b>Baltimore 22, Maryland</b>			
22a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/4/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Gentryes Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Boonesville, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk 22, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 6 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Fries</b>			

CERTIFICATE OF DEATH

1953

1. PLACE OF DEATH		2. COUNTY	
BALTIMORE		BALTIMORE	
3. SEX		4. AGE	
MALE		35	
5. RACE		6. OCCUPATION	
WHITE		LABORER	
7. MARITAL STATUS		8. CAUSE OF DEATH	
MARRIED		HEART DISEASE	
9. DATE OF DEATH		10. TIME OF DEATH	
JANUARY 15, 1953		10:00 AM	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES	
[Signature]		[Signatures]	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER	
[Signature]		[Signature]	
15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF CLERK	
[Signature]		[Signature]	

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MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MAYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MAYLAND</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>				c. LENGTH OF STAY IN 1b <b>3 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STOCKTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>				d. STREET ADDRESS <b>23X-2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM HOLLAND PRICE</b>				4. DATE OF DEATH Month Day Year <b>JUNE 11 1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-14-1869</b>		9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OSTER BUSINESS</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MAYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>GIDEON PRICE</b>				14. MOTHER'S MAIDEN NAME <b>ANNA ADAMS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Frank L. Smith Jr. - Cockeysville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4-22-1</b> DUE TO <b>Arterio Sclerotic Cardio Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-2</b> 19 <b>61</b> to <b>6-9</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>6-9</b> 19 <b>61</b> , and that death occurred at <b>1:25 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Walter T. Kees</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6/11/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>				22d. ADDRESS <b>COCKEYSVILLE, MD</b>			
23a. BURIAL, CREMATION, (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-14-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gunby Presbyterian</b>		23d. LOCATION (City, town, or county) (State) <b>Stockton, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 13 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

CONTINUED IN DEATH

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TRAVELING

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 06535

6551

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>3403 Gata Cuba Drive</u>		d. STREET ADDRESS <u>3403 Gata Cuba Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Anna</u> First <u>Rabinowitz</u> Middle <u>R</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>60</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
13. FATHER'S NAME <u>Arnon Friedman</u>		14. MOTHER'S MAIDEN NAME <u>Jennie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Philip Rabinowitz</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>193.0</u> DUE TO <u>Cerebral Malignant Tumor</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5-months</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 15, 1961</u> , to <u>June 3, 1961</u> , that I last saw the deceased alive on <u>June 3, 1961</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. Herman Seidel</u> M.D.		ADDRESS (Street, city or town, state) <u>2404 Euteria Pl.</u> DATE SIGNED <u>6/4/61</u>	
PHYSICIAN'S NAME (Type) <u>HERMAN SEIDEL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremated</u>	22b. DATE THEREOF <u>6-4-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2106 Euteria Pl.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 6 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>17. SIGNATURE OF CHURCH OFFICIAL</p>		<p>18. SIGNATURE OF FUNERAL HOME</p>	
<p>19. SIGNATURE OF CEMETERY OFFICIAL</p>		<p>20. SIGNATURE OF INTERVIEWER</p>	
<p>21. SIGNATURE OF CORONER</p>		<p>22. SIGNATURE OF JURY</p>	
<p>23. SIGNATURE OF JUDGE</p>		<p>24. SIGNATURE OF CLERK</p>	
<p>25. SIGNATURE OF SHERIFF</p>		<p>26. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>27. SIGNATURE OF CONSTABLE</p>		<p>28. SIGNATURE OF JURY</p>	
<p>29. SIGNATURE OF JUDGE</p>		<p>30. SIGNATURE OF CLERK</p>	
<p>31. SIGNATURE OF SHERIFF</p>		<p>32. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>33. SIGNATURE OF CONSTABLE</p>		<p>34. SIGNATURE OF JURY</p>	
<p>35. SIGNATURE OF JUDGE</p>		<p>36. SIGNATURE OF CLERK</p>	
<p>37. SIGNATURE OF SHERIFF</p>		<p>38. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>39. SIGNATURE OF CONSTABLE</p>		<p>40. SIGNATURE OF JURY</p>	
<p>41. SIGNATURE OF JUDGE</p>		<p>42. SIGNATURE OF CLERK</p>	
<p>43. SIGNATURE OF SHERIFF</p>		<p>44. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>45. SIGNATURE OF CONSTABLE</p>		<p>46. SIGNATURE OF JURY</p>	
<p>47. SIGNATURE OF JUDGE</p>		<p>48. SIGNATURE OF CLERK</p>	
<p>49. SIGNATURE OF SHERIFF</p>		<p>50. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>51. SIGNATURE OF CONSTABLE</p>		<p>52. SIGNATURE OF JURY</p>	
<p>53. SIGNATURE OF JUDGE</p>		<p>54. SIGNATURE OF CLERK</p>	
<p>55. SIGNATURE OF SHERIFF</p>		<p>56. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>57. SIGNATURE OF CONSTABLE</p>		<p>58. SIGNATURE OF JURY</p>	
<p>59. SIGNATURE OF JUDGE</p>		<p>60. SIGNATURE OF CLERK</p>	
<p>61. SIGNATURE OF SHERIFF</p>		<p>62. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>63. SIGNATURE OF CONSTABLE</p>		<p>64. SIGNATURE OF JURY</p>	
<p>65. SIGNATURE OF JUDGE</p>		<p>66. SIGNATURE OF CLERK</p>	
<p>67. SIGNATURE OF SHERIFF</p>		<p>68. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>69. SIGNATURE OF CONSTABLE</p>		<p>70. SIGNATURE OF JURY</p>	
<p>71. SIGNATURE OF JUDGE</p>		<p>72. SIGNATURE OF CLERK</p>	
<p>73. SIGNATURE OF SHERIFF</p>		<p>74. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>75. SIGNATURE OF CONSTABLE</p>		<p>76. SIGNATURE OF JURY</p>	
<p>77. SIGNATURE OF JUDGE</p>		<p>78. SIGNATURE OF CLERK</p>	
<p>79. SIGNATURE OF SHERIFF</p>		<p>80. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>81. SIGNATURE OF CONSTABLE</p>		<p>82. SIGNATURE OF JURY</p>	
<p>83. SIGNATURE OF JUDGE</p>		<p>84. SIGNATURE OF CLERK</p>	
<p>85. SIGNATURE OF SHERIFF</p>		<p>86. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>87. SIGNATURE OF CONSTABLE</p>		<p>88. SIGNATURE OF JURY</p>	
<p>89. SIGNATURE OF JUDGE</p>		<p>90. SIGNATURE OF CLERK</p>	
<p>91. SIGNATURE OF SHERIFF</p>		<p>92. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>93. SIGNATURE OF CONSTABLE</p>		<p>94. SIGNATURE OF JURY</p>	
<p>95. SIGNATURE OF JUDGE</p>		<p>96. SIGNATURE OF CLERK</p>	
<p>97. SIGNATURE OF SHERIFF</p>		<p>98. SIGNATURE OF DEPUTY SHERIFF</p>	
<p>99. SIGNATURE OF CONSTABLE</p>		<p>100. SIGNATURE OF JURY</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined and within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
6552 CERTIFICATE OF DEATH 06536													
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>							
c. LENGTH OF STAY IN 1b <b>143 Days</b>						d. STREET ADDRESS <b>1423 Eighth Street</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>KEVICK</b>			First <b>H.</b> Middle <b>REEDER</b> Last <b>June</b>			4. DATE OF DEATH <b>June 10, 19 61</b>			Month <b>10</b> Day <b>19</b> Year <b>61</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 8, 1921</b>		9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>File Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John H. Reeder</b>						14. MOTHER'S MAIDEN NAME <b>Anna Washington</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW-11</b>						16. SOCIAL SECURITY NO. <b>578-12-2227</b>						17. INFORMANT <b>Clin. Rec. VAH, Baltimore 18, Md.-Ft Howard Div.</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>150X</b> IMMEDIATE CAUSE (a) <b>SQUAMOUS CELL CARCINOMA OF ESOPHAGUS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cachexia</b>										INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that <b>X</b> (this hospital) attended the deceased from <b>January 18, 1961</b> to <b>June 10, 1961</b> that <b>W</b> (we) last saw the deceased alive on <b>June 10, 1961</b> , and that death occurred at <b>8:30 p.m.</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>Joseph J. Cillo M.D.</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>6-11-61</b>				
22c. PHYSICIAN'S NAME (Type) <b>Joseph J. Cillo, M.D.</b>						22d. ADDRESS <b>VAH, Baltimore 18 Md - Ft Howard Div.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-12-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Arlington Virginia</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S Phillips</b>				ADDRESS <b>1808-10 N Monroe St Baltimore 17 Md</b>				25a. REC'D BY REGISTRAR <b>DATE JUN 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

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Director of Education

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6553

## CERTIFICATE OF DEATH

Reg. Dist. No. 06537

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2910 Greentop Road</b>				d. STREET ADDRESS <b>2910 Greentop Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>Elizabeth</b> Last <b>Reese</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>16</b> Year <b>1961</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1901</b>		9. AGE (In years last birthday) yrs. <b>60</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Grant McKaig</b>				14. MOTHER'S MAIDEN NAME <b>Ida May McKaig</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Henry David Reese, Jr.</b> Address <b>Cockeysville 2910 Greentop Rd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE CEREBROVASCULAR DISEASE</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 HRS</b> <b>5 YRS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>JUNE 12, 1961</b> , to <b>JUNE 16, 1961</b> , that I last saw the deceased alive on <b>JUNE 12, 1961</b> , and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2060 YORK RD</b> DATE SIGNED <b>6/19/61</b> ACTUAL SIGNATURE <b>William A. Pillsbury</b> M.D. <b>TIMONUM MD.</b> PHYSICIAN'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6-19-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street, Baltimor</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 20 '61</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Thayer</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Items 13 & 14 Film G289 6/30/61											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holly Hill Manor</b> <b>531 Stevenson Lane</b>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> d. STREET ADDRESS <b>1108 Sleepy Dell Court</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Stanley G. Remington</b>						4. DATE OF DEATH June 23, 1961					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 5th 1875</b>		9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chairman of Board</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Remington Books</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>						14. MOTHER'S MAIDEN NAME <b>unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give year or dates of service)</b>						16. SOCIAL SECURITY NO. <b>17. INFORMANT</b> Address <b>Mr. John T. Remington-1108 Sleepy Dell Court</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO <b>Arteriosclerosis (C.V.D.)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>June 19, 1961</b> to <b>June 23, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 19, 1961</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Charles E. Carr, Jr.</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6/23/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Charles E. Carr, Jr.</b>						22d. ADDRESS <b>6201 York Road, Balto. 12, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6-26-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Jim J. Teckner &amp; Son</b>						ADDRESS <b>North Penna Ave Balto 17, Md</b>		25a. REC'D BY REGISTRAR <b>JUN 26 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>	

00333

(M)

(1)

W. O. Carter, Jr., 100 York Road, Balto., Md.

Baltimore, Maryland

Washington, D. C.

100 York Road, Balto., Md.

100 York Road, Balto., Md.

Washington, D. C.

100 York Road, Balto., Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

6555

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06539

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>675 Washington Blvd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Newman</b> Last <b>Richards</b>		4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1890</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>12</b> Hours <b>19</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>florist supplies</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Georgia</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Richards</b>		14. MOTHER'S MAIDEN NAME <b>Mary Wille</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decompensatory heart failure</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Arteriosclerosis, generalized and severe</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 5, 1961</b> to <b>June 12, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 12, 1961</b> , and that death occurred at <b>5:55</b> A. M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Loretta Hsu</b>		22b. DATE SIGNED <b>6-12-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Loretta Hsu, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/14/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		25a. REC'D BY REGISTRAR <b>4107 Wilkens Ave.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		DATE <b>JUN 14 '61</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06540

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u> c. LENGTH OF STAY IN 1b <u>22 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8037 Old Philadelphia Rd</u>		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u> d. STREET ADDRESS <u>8037 Old Philadelphia Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph John Ritko Sr.</u>		4. DATE OF DEATH <u>JUN 13 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 9, 1911</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crane operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Ritko</u>		14. MOTHER'S MAIDEN NAME <u>Anna Susko</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-073605</u>	
17. INFORMANT <u>Mary Ritko</u>		Address <u>8037 Old Philadelphia Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> 178X DUE TO (b) <u>CARCINOMA OF TESTICLE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>2 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1960</u> to <u>June 13, 1961</u> that (I) (we) last saw the deceased alive on <u>June 12, 1961</u> , and the death occurred at <u>1 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Jim Baumgardner</u> M.D.		22b. DATE SIGNED <u>6/13/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Balto 6 Md.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>June 16, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Czech</u>		25a. REC'D BY REGISTRAR <u>1211 Chesapeake Ave.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		DATE <u>JUN 16 '61</u>	

TO FURNISH OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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Joseph John William 1911-1912

Joseph John William 1911-1912

1911-1912

1911-1912

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1911-1912



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6557

06541

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN lb <b>76 Days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>121 Berlin Ave</b>			
3. NAME OF DECEASED (Type or print) <b>HERMAN R ROSE</b>				4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>June 3, 1907</b>	
9. AGE (In years last birthday) <b>53 yrs.</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>61</b>		IF UNDER 24 HRS. Months <b>1</b> Days <b>19</b> Hours <b>61</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel Co. Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William Rose</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Cook</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <b>Yes WW II</b>				16. SOCIAL SECURITY NO. <b>216-05-5547</b>			
17. INFORMANT <b>Clin.Rec., VAH Balto 18, Md., Ft Howard Division</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PURULENT CHOLANGITIS WITH ABSCESES OF THE LIVER</b> 585X <b>ADENOCARCINOMA CECUM WITH METASTASES TO LYMPH</b> Conditions, if any, which gave rise to immediate cause (b) <b>NOBES AND LIVER</b> (a), stating the underlying cause last. <b>BRONCHOPNEUMONIA</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>1 1/2 years UNKNOWN</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (x) (this hospital) attended the deceased from <b>March 17, 1961</b> to <b>June 1, 1961</b> , that (u) (we) last saw the deceased alive on <b>June 1, 1961</b> , and that death occurred at <b>10:05PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Walter J. Pijanowski</b>				22b. DATE SIGNED <b>6/2/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>WALTER J. PIJANOWSKI, M.D.</b>				22d. ADDRESS <b>VAH BALTO 18, MD FT HOWARD DIV.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/6/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Katie R. Williams</b>				25a. REC'D BY REGISTRAR <b>JUN 5 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>							

TO CAPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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To Day

Port House

121 1/2 Ave

Veterans Administration Hospital

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June 3, 1907

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Place

U.S.A. Anne Arundel Co. Maryland

Civil Bureau

Washington

Small Cook

Marion Rose

W. II. Sigsbee, Esq., Van Buren St., St. Louis, Mo.

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AND ASSOCIATED CHICAGO WITH MEMBERS TO LIVER

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MOORE AND LIVER

NEW

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June 1, 1907

June 1, 1907

VAN BUREN ST., ST. LOUIS, MO.

WILLIAM C. BISHOP, M.D.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Radio R. Williams 322 N. Boulevard St. Louis Mo

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

6553

06542

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>2925 Rockrose Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Trees</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>E</u> Last <u>Roseman</u>				4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-16-1890</u>		9. AGE (In years last birthday) <u>71</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocer</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arnon?</u>				14. MOTHER'S MAIDEN NAME <u>Esther?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Belle Roseman - Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1955</u> to <u>June 28, 1961</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>June 28, 1961</u> , and that death occurred at <u>7 P.</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Samuel J. Pelicciotti</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/30/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Samuel J. Pelicciotti</u>				22d. ADDRESS <u>2320 Eutan Place</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-30-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Herring Run</u>		23d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Kuri</u>				ADDRESS <u>2100 Eutan Place</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 5 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kimes</u>			

TO HOUSING OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6559

Reg. Dist. No. **06543**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point, Md.</b>		c. LENGTH OF STAY IN 1b  		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Inverness (22)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Bethlehem Steel Co. Dispensary</b>				d. STREET ADDRESS <b>1955 Haselmere Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <b>Pietro Bruno SACILOTTO</b>				<b>4. DATE OF DEATH</b> <b>June 6th, 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>Aug. 7th, 1910</b>		9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR: Months <b>6</b> Days <b>6</b>			
IF UNDER 24 HRS.: Hours <b>16</b> Mln. <b>1</b>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
<b>13. FATHER'S NAME</b> <b>Louis Sacilotto</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Amelia Pittle</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>212-01-9182</b>		<b>17. INFORMANT</b> <b>Mrs. Jean C. Sacilotto</b> Address <b>same as #2</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
ACTUAL SIGNATURE <b>Jack C. Collins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6-6-61</b>			
EXAMINER'S NAME (Type) <b>JACK C COLLINS</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/9/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>			
22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk 22</b>				24a. REC'D BY REGISTRAR <b>DATE JUN 12 1961</b>			
ADDRESS				24b. REGISTRAR'S SIGNATURE			

TO: COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose this certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES B. JEFFERSON		AGE 50		SEX Male		RACE White		DATE OF DEATH May 10, 1910		PLACE OF DEATH Home	
RESIDENCE 1005 Adams Road		CITY Baltimore		COUNTY Baltimore		STATE Maryland		OCCUPATION None		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		DISEASE OR INJURY None		TOXIC None		OTHER None		SIGNATURE OF EXAMINER J. B. Jefferson		DATE May 10, 1910	
SIGNATURE OF NEXT OF KIN None		SIGNATURE OF PHYSICIAN None		SIGNATURE OF CLERGYMAN None		SIGNATURE OF JURY None		SIGNATURE OF CORONER None		SIGNATURE OF DECEASED None	



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6560

06544

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence Before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATON S VILLE</b>		c. LENGTH OF STAY in 1b <b>23 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X</b>		d. STREET ADDRESS <b>4717 ALDGA TE GREEN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>M.</b> Last <b>S AUERWALD</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>15</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 24, 1877</b>		9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hous ewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Un known</b>				14. MOTHER'S MAIDEN NAME <b>Unrnown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: Spring Gr ove Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute biliary obst ruction</b> <b>584X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Calculus in common Bile Duct</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Arterios cleroti Car diovascular Disease</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>May 23, 19 61</b> to <b>June 15, 19 61</b> , that (I) (we) last saw the deceased alive on <b>June 15, 19 61</b> , and that death occurred at <b>8:13</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>José R. Arizaga</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>6 15 61</b>			
22c. PHYSICIAN'S NAME (Type) <b>José R. Arizaga M.D.</b>				22d. ADDRESS <b>Spring Grove Hospital Catonsville 28, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-19-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>London Park</b>		23d. LOCATION (City, town or county) (State) <b>Balti - Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Mr. Lipton &amp; Son - Catonsville - 28 - Md.</b>				25a. REC'D BY REGISTRAR <b>JUN 21 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6561

06545

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY in 1b <b>10 days</b>		d. STREET ADDRESS <b>11620 Forest Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Schumann</b> Last <b>Schumann</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>29</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mid 1869</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foundry Worker</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Copper Co.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Md. United States</b>
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown MARY HEFFNER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkwn) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mildred Beisinger</b>		Address <b>1620 Forest Park, Balto.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <b>June 19, 1961</b> , to <b>June 29, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 29, 1961</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>6-29-61</b>
22a. SIGNATURE <b>Stella Wachslar</b> M.D.		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>7/1/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LONDON PARK CEM BALTO. Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>G. TRUMAN Schwab</b>		25a. REC'D BY REGISTRAR <b>JUL 3 '61</b>
ADDRESS <b>3512 Fred. Ave.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Item 2 & 7 Form 0289 6/29/61 mh  
6562

**CERTIFICATE OF DEATH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY <b>Balto</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATonsville</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Summit NURS. Hm.</b>		d. STREET ADDRESS <b>1613 Light St. 3V01-4</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Rose</b> Middle <b>Sciacca</b> Last <b>Sciacca</b>		4. DATE OF DEATH Month <b>6-</b> Day <b>21</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>— 1870</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unk</b>		14. MOTHER'S MAIDEN NAME <b>unk</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Family</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>450.0</b> IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma Vaginal Wall resected 8/2/60</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19 Mar 1960</b> to <b>6/21/61</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>9/20/61</b> and that death occurred at <b>8:45 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W.E. McGrath MD.</b>		22b. DATE SIGNED <b>6/21/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>W.E. McGrath MD.</b>		22d. ADDRESS <b>1303 Frederick Rd</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>6-24-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Calverton</b>		23d. LOCATION (City, town, or county) (State) <b>Balto</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Homes</b>		ADDRESS <b>130 E. Fort Ave</b>	
25a. REC'D BY REGISTRAR <b>DATE 26 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
6563					06547				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>					c. LENGTH OF STAY IN 1b <u>25 yrs.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Training School</u>					d. STREET ADDRESS <u>None</u>				
3. NAME OF DECEASED (Type or print) <u>Twila Ruth Shaffer</u>					4. DATE OF DEATH Month <u>6</u> Day <u>28</u> Year <u>19 61</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/30/1917</u>		9. AGE (In years last birthday) <u>43</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Garrett County, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Benjamin Franklin Shaffer (deceased)</u>					14. MOTHER'S MAIDEN NAME <u>Eula Catherine Elsey (deceased)</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>-</u>				
17. INFORMATION <u>Rosewood Records, Owings Mills, Maryland</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Back and chronic bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>									
20c. TIME OF INJURY Hour <u>a.m.</u> <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>			
21. I certify that (I) (this hospital) attended the deceased from <u></u> , 19 <u></u> , to <u></u> , 19 <u></u> , that (I) (we) last saw the deceased alive on <u></u> , 19 <u></u> , and that death occurred at <u>10:00</u> from <u>the</u> causes and on the date stated above.									
22a. SIGNATURE <u>Pete W. Rieckert</u> M.D.					22b. DATE SIGNED <u>6-24-61</u>				
22c. PHYSICIAN'S NAME (Type) <u>Pete W. Rieckert</u>					22d. ADDRESS <u>4307 Mainfield Ave Balto 14</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/1/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley Cemetery</u>		23d. LOCATION (City, town or county) <u>Garrett County</u>		(State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Leighton</u>					25a. REC'D BY REGISTRAR <u>Oakland, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		

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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "MAY 1941" and "OFFICE" are faintly visible.]*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6564

## CERTIFICATE OF DEATH

Reg. Dist. No. 06548

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1mth29dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>332 Montgomery Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Frances</b> Last <b>Shipe</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>19 61</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
9. AGE (In years last birthday) <b>59</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>restaurant owner</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Franklin Knisley</b>		14. MOTHER'S MAIDEN NAME <b>Deola Feltner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk own</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple metastases</b> DUE TO <b>Carcinoma of the thyroid</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 20, 1961</b> to <b>June 20, 1961</b> , that I last saw the deceased alive on <b>June 20, 1961</b> , and that death occurred at <b>10:35 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D.		DATE SIGNED <b>6-21-61</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial June 24, 1961</b>		22b. DATE THEREOF <b>June 24, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Laurel, Md</b>		22d. LOCATION (City, town, or county) (State) <b>Laurel, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lewis &amp; Malden</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 27 '61</b>	
ADDRESS <b>313 Talbot St</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kruza</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1955

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. PLACE OF DEATH</p>		<p>10. DATE OF DEATH</p>		<p>11. TIME OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF JUDGE</p>	
<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF REGISTRAR</p>		<p>19. SIGNATURE OF SHERIFF</p>		<p>20. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>21. SIGNATURE OF SHERIFF'S CLERK</p>		<p>22. SIGNATURE OF SHERIFF'S CLERK</p>		<p>23. SIGNATURE OF SHERIFF'S CLERK</p>		<p>24. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>25. SIGNATURE OF SHERIFF'S CLERK</p>		<p>26. SIGNATURE OF SHERIFF'S CLERK</p>		<p>27. SIGNATURE OF SHERIFF'S CLERK</p>		<p>28. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>29. SIGNATURE OF SHERIFF'S CLERK</p>		<p>30. SIGNATURE OF SHERIFF'S CLERK</p>		<p>31. SIGNATURE OF SHERIFF'S CLERK</p>		<p>32. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>33. SIGNATURE OF SHERIFF'S CLERK</p>		<p>34. SIGNATURE OF SHERIFF'S CLERK</p>		<p>35. SIGNATURE OF SHERIFF'S CLERK</p>		<p>36. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>37. SIGNATURE OF SHERIFF'S CLERK</p>		<p>38. SIGNATURE OF SHERIFF'S CLERK</p>		<p>39. SIGNATURE OF SHERIFF'S CLERK</p>		<p>40. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>41. SIGNATURE OF SHERIFF'S CLERK</p>		<p>42. SIGNATURE OF SHERIFF'S CLERK</p>		<p>43. SIGNATURE OF SHERIFF'S CLERK</p>		<p>44. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>45. SIGNATURE OF SHERIFF'S CLERK</p>		<p>46. SIGNATURE OF SHERIFF'S CLERK</p>		<p>47. SIGNATURE OF SHERIFF'S CLERK</p>		<p>48. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>49. SIGNATURE OF SHERIFF'S CLERK</p>		<p>50. SIGNATURE OF SHERIFF'S CLERK</p>		<p>51. SIGNATURE OF SHERIFF'S CLERK</p>		<p>52. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>53. SIGNATURE OF SHERIFF'S CLERK</p>		<p>54. SIGNATURE OF SHERIFF'S CLERK</p>		<p>55. SIGNATURE OF SHERIFF'S CLERK</p>		<p>56. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>57. SIGNATURE OF SHERIFF'S CLERK</p>		<p>58. SIGNATURE OF SHERIFF'S CLERK</p>		<p>59. SIGNATURE OF SHERIFF'S CLERK</p>		<p>60. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>61. SIGNATURE OF SHERIFF'S CLERK</p>		<p>62. SIGNATURE OF SHERIFF'S CLERK</p>		<p>63. SIGNATURE OF SHERIFF'S CLERK</p>		<p>64. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>65. SIGNATURE OF SHERIFF'S CLERK</p>		<p>66. SIGNATURE OF SHERIFF'S CLERK</p>		<p>67. SIGNATURE OF SHERIFF'S CLERK</p>		<p>68. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>69. SIGNATURE OF SHERIFF'S CLERK</p>		<p>70. SIGNATURE OF SHERIFF'S CLERK</p>		<p>71. SIGNATURE OF SHERIFF'S CLERK</p>		<p>72. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>73. SIGNATURE OF SHERIFF'S CLERK</p>		<p>74. SIGNATURE OF SHERIFF'S CLERK</p>		<p>75. SIGNATURE OF SHERIFF'S CLERK</p>		<p>76. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>77. SIGNATURE OF SHERIFF'S CLERK</p>		<p>78. SIGNATURE OF SHERIFF'S CLERK</p>		<p>79. SIGNATURE OF SHERIFF'S CLERK</p>		<p>80. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>81. SIGNATURE OF SHERIFF'S CLERK</p>		<p>82. SIGNATURE OF SHERIFF'S CLERK</p>		<p>83. SIGNATURE OF SHERIFF'S CLERK</p>		<p>84. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>85. SIGNATURE OF SHERIFF'S CLERK</p>		<p>86. SIGNATURE OF SHERIFF'S CLERK</p>		<p>87. SIGNATURE OF SHERIFF'S CLERK</p>		<p>88. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>89. SIGNATURE OF SHERIFF'S CLERK</p>		<p>90. SIGNATURE OF SHERIFF'S CLERK</p>		<p>91. SIGNATURE OF SHERIFF'S CLERK</p>		<p>92. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>93. SIGNATURE OF SHERIFF'S CLERK</p>		<p>94. SIGNATURE OF SHERIFF'S CLERK</p>		<p>95. SIGNATURE OF SHERIFF'S CLERK</p>		<p>96. SIGNATURE OF SHERIFF'S CLERK</p>	
<p>97. SIGNATURE OF SHERIFF'S CLERK</p>		<p>98. SIGNATURE OF SHERIFF'S CLERK</p>		<p>99. SIGNATURE OF SHERIFF'S CLERK</p>		<p>100. SIGNATURE OF SHERIFF'S CLERK</p>	

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FOR STATE  
HEALTH DEPT.

Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
06549

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River #20</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>62 Kingston Park</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Lancaster</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>York</u> d. STREET ADDRESS <u>634 Wheatland Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JULIUS PRESTON SHUTZ</u> First Middle Last				4. DATE OF DEATH <u>June 15 1961</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 25, 1884</u> 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Henry Shutz</u>				14. MOTHER'S MAIDEN NAME <u>Joanna Reeling</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Julius P. Shutz Jr. Box 155 Pasadena, Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerosis and Hypertension</u> 443 x DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardio-Vascular Disease</u> DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M.B. Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M.B. Davis, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>June 15-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6/25/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sleeper Funeral Home</u>		22d. LOCATION (City, town, or country) (State) <u>York, Penna.</u>	
23. FUNERAL DIRECTOR <u>James E. Bruzdziński</u> ADDRESS <u>1407 Eastern Ave. #21</u>				24a. REC'D BY REGISTRAR <u>JUN 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

2

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(M)

(1)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
to be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06550

1. PLACE OF DEATH a. COUNTY <u>1112 Harper Rd</u> <u>JAMES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN IB <u>20 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Co Md</u>		d. STREET ADDRESS <u>412 Hopkins Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES C SKIRVAN</u>		4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/18/1872</u> 68 yrs.
9. AGE (In years lost birthday)		IF UNDER 1 YEAR Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>	IF UNDER 24 HRS.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patrol</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>			
13. FATHER'S NAME <u>Anthony Skirvan</u>		14. MOTHER'S MAIDEN NAME <u>Donna Skirvan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-07-4703</u>	
17. INFORMANT <u>Joseph Skirvan</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive-arteriosclerotic</u> (c) <u>Cardiomyopathic disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus due to chronic hepatitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 19, 1959</u> , to <u>Jan 17, 1961</u> , that I last saw the deceased alive on <u>May 30, 1961</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frederick J. Vollmer</u> M.D.		ADDRESS (Street, city or town, state) <u>6100 York Rd</u> DATE SIGNED <u>Jan 17, 1961</u>	
PHYSICIAN'S NAME (Type) <u>FREDERICK J. VOLLMER</u>		<u>BALTO-12 MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/20/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Marland</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Foley &amp; Sons</u> ADDRESS <u>1318 Light</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Krause</u> DATE <u>JUN 21 '61</u>	
		24b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6567  
CERTIFICATE OF DEATH

Reg. Dist. No. 06551

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>5313 Edmonson Ave</b>		c. LENGTH OF STAY IN 1b <b>X Baltimore Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hood Nursing Home</b>		d. STREET ADDRESS <b>5628 Carville Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>A.</b> Last <b>SLATER</b>		4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 19-1887</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min. <b>74</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvanis.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Miles Fleeger</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>George H. Slater</b>		Address <b>5628 Carville Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Congestive Failure</b> DUE TO (b) <b>Arterio-sclerotic Cardiac</b> DUE TO (c) <b>Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 58</b> , 19 <b>61</b> , to <b>6/15</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>6/15</b> , 19 <b>61</b> , and that death occurred at <b>2:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1311 Francis Ave</b> DATE SIGNED ACTUAL SIGNATURE <b>J. N. Frederick</b> M.D. <b>Balto. 27, Md.</b> PHYSICIAN'S NAME (Type) <b>J. N. Frederick</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 19/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Henry</b>		ADDRESS <b>5646 Carville Ave.</b>	
24a. REC'D BY REGISTRAR <b>JUN 20 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur P. Hanna</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1900</i>		5. PLACE OF BIRTH <i>Johns Hopkins</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Jan 15 1920</i>		9. NAME OF SPOUSE <i>Jane Doe</i>		10. PLACE OF MARRIAGE <i>St. John's Church</i>		11. DATE OF DEATH <i>Jan 15 1945</i>		12. PLACE OF DEATH <i>Home</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. MEDICAL HISTORY <i>None</i>		15. PRESENT ILLNESS <i>None</i>		16. DATE OF ONSET <i>None</i>		17. DATE OF TERMINATION <i>None</i>		18. DATE OF RECOVERY <i>None</i>	
19. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>		20. NAME OF HOSPITAL <i>None</i>		21. NAME OF NURSE <i>None</i>		22. NAME OF ATTENDING PHYSICIAN <i>None</i>		23. NAME OF ASSISTANT PHYSICIAN <i>None</i>		24. NAME OF PATHOLOGIST <i>None</i>	
25. NAME OF CORONER <i>None</i>		26. NAME OF JURY <i>None</i>		27. NAME OF JUDGE <i>None</i>		28. NAME OF CLERK <i>None</i>		29. NAME OF RECORDS <i>None</i>		30. NAME OF OFFICE <i>None</i>	

1

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR THE CORONER, AND IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **06552**

6568

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>unknown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines N.H.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Conrad</b>		First		Middle		Last <b>Smit</b>	
4. DATE OF DEATH		Month <b>6</b>		Day <b>23</b>		Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 24, 1878</b>		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Otis Smit</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Marie Bierau, 419 S. Bouldin St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial De-compensation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>1230.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-12-1961</b> , to <b>6-23-1961</b> , that I last saw the deceased alive on <b>6-22-1961</b> , and that death occurred at <b>5:00</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wilmer K. Gallager</b>				ADDRESS (Street, city or town, state) <b>6209 Frederick Ave Baltimore-28, Md.</b>		DATE SIGNED <b>6-24-61</b>	
PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallager</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>June 26, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Ullrich Funeral Homes, Baltimore, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 27 61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of medical examiner		11. Signature of coroner		12. Signature of jury	
13. Signature of witness		14. Signature of witness		15. Signature of witness		16. Signature of witness	
17. Signature of witness		18. Signature of witness		19. Signature of witness		20. Signature of witness	
21. Signature of witness		22. Signature of witness		23. Signature of witness		24. Signature of witness	
25. Signature of witness		26. Signature of witness		27. Signature of witness		28. Signature of witness	
29. Signature of witness		30. Signature of witness		31. Signature of witness		32. Signature of witness	
33. Signature of witness		34. Signature of witness		35. Signature of witness		36. Signature of witness	
37. Signature of witness		38. Signature of witness		39. Signature of witness		40. Signature of witness	
41. Signature of witness		42. Signature of witness		43. Signature of witness		44. Signature of witness	
45. Signature of witness		46. Signature of witness		47. Signature of witness		48. Signature of witness	
49. Signature of witness		50. Signature of witness		51. Signature of witness		52. Signature of witness	
53. Signature of witness		54. Signature of witness		55. Signature of witness		56. Signature of witness	
57. Signature of witness		58. Signature of witness		59. Signature of witness		60. Signature of witness	
61. Signature of witness		62. Signature of witness		63. Signature of witness		64. Signature of witness	
65. Signature of witness		66. Signature of witness		67. Signature of witness		68. Signature of witness	
69. Signature of witness		70. Signature of witness		71. Signature of witness		72. Signature of witness	
73. Signature of witness		74. Signature of witness		75. Signature of witness		76. Signature of witness	
77. Signature of witness		78. Signature of witness		79. Signature of witness		80. Signature of witness	
81. Signature of witness		82. Signature of witness		83. Signature of witness		84. Signature of witness	
85. Signature of witness		86. Signature of witness		87. Signature of witness		88. Signature of witness	
89. Signature of witness		90. Signature of witness		91. Signature of witness		92. Signature of witness	
93. Signature of witness		94. Signature of witness		95. Signature of witness		96. Signature of witness	
97. Signature of witness		98. Signature of witness		99. Signature of witness		100. Signature of witness	



RECEIVED  
BALTIMORE  
MAY 10 1910



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only a deputy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

(M)

X

(I)

03

2

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6563

Reg. Dist. No. 06553

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN 1b <b>? Hours</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Inverness Bathing Beach, Bear Creek</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> d. STREET ADDRESS <b>8010 Kavanaugh Rd. 22, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cheryl</b> Middle <b>Ann</b> Last <b>Sollars</b>		4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>1961</b>	
5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 26, 1950</b> 9. AGE (In years last birthday) <b>11</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grange Elementary</b> 11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A..</b>	
13. FATHER'S NAME <b>Walter Sollars</b>		14. MOTHER'S MAIDEN NAME <b>Uvee Tyler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not, or unknown) <b>None</b> (If not, give dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Walter Sollars</b>		Address <b>8010 Kavanaugh Rd..</b>	
18. CAUSE OF DEATH [Enter only one cause per line (or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning - Accidental</b> <b>929.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>She and playmate were floating on their backs</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>6/14</b> p. m. <b>1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Bear Creek</b> 20f. (City or town) <b>Dundalk</b> (County) <b>Balto</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Jack Collins</b> M.D. EXAMINER'S NAME (Type) <b>Jack Collins, MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 18, 1961</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cem.</b> 22d. LOCATION (City, town, or county) (State) <b>Elk Garden, West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN J. DUDA</b> ADDRESS <b>7922 Wise Ave. 22, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 19 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>	



6570

CERTIFICATE OF DEATH

Reg. Dist. No.

06554

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Monkton</b>		c. LENGTH OF STAY IN lb <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shepperd Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charlotte Payne Sparks</b>		4. DATE OF DEATH Month <b>6</b> Day <b>21</b> Year <b>61</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-17-1879</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dr. Thomas Payne</b>		14. MOTHER'S MAIDEN NAME <b>Emma Ross</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Dorothy S. Hutchins,</b>		Address <b>above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiac Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19 <b>45</b> , to <b>June 21</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>June 20</b> , 19 <b>61</b> , and that death occurred at <b>2:22 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>PARKTON, Md.</b> DATE SIGNED <b>6/22/61</b>			
ACTUAL SIGNATURE <b>A. M. France</b> M.D.		PHYSICIAN'S NAME (Type) <b>A. M. FRANCE</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-23-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. James</b>		22d. LOCATION (City, town, or county) (State) <b>Monkton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson</b>		ADDRESS <b>4, Md.</b>	
24a. REC'D BY REGISTRAR <b>BUN 26 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

County of Suffolk State of Massachusetts

City of Boston

Death of Charles Edward

Age 25 years

Sex Male

Married Yes

Signature of Physician

Signature of Registrar

Signature of Witness

Signature of Witness

Signature of Witness

Signature of Witness

Signature of Witness

Signature of Witness

Signature of Witness

Signature of Witness

Signature of Witness

Reg. Dist. No. 06555

MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/5B

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

SIGNATURE OF MINISTER

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF REGISTRAR

SIGNATURE OF REGISTRAR

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF WITNESS

SIGNATURE OF WITNESS

DATE OF SIGNATURE



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

6572

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06556

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fullerton</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8511 Belair Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>Steg</b> Last <b>Steg</b>				4. DATE OF DEATH Month <b>6</b> Day <b>8</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-19-1875</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>86</b> Days <b>8</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Months <b>86</b> Days <b>8</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto. Co.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>George Hagley</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Leonard E. Steg 9118 Belair Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of head of pancreas</b> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>—</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardiovascular disease</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>Jan 1960</b> to <b>June 8, 1961</b> , that (I) (we) last saw the deceased alive on <b>6/5 1961</b> and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>H. A. Grott</b>				22b. DATE SIGNED <b>6/9/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>H. A. GROTT, MD</b>				22d. ADDRESS <b>8100 Harford Rd.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-12-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Parkville Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home</b>				ADDRESS <b>7401 Belair Road</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 12 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>			

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*[Faint, mostly illegible handwriting at the bottom of the page, possibly containing a signature or date.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
6573 Item 8 Film G288 6/12/61 iwk 06557														
1. PLACE OF DEATH e. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN lb <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Codd Convalescent Home</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b> d. STREET ADDRESS <b>6512 Maplewood Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN EDWARD SULLENS</b>					4. DATE OF DEATH Month Day Year <b>June 1, 1961</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 1, 1878 1877</b>		9. AGE (In years last birthday) <b>83</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman- retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>American Can Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>						
13. FATHER'S NAME <b>William H. Sullens</b>					14. MOTHER'S MAIDEN NAME <b>Johanna Hubbard</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service) <b>None</b>					16. SOCIAL SECURITY NO. <b>212-09-5093</b>					17. INFORMANT <b>Family Records</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Hypertension Cardio Vascular Disease</b> 442X DUE TO (b) <b>Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) <b>Baltimore</b>		(State) <b>Maryland</b>				
21. I certify that (I) (his/her) attended the deceased from <b>Jan 10 1950</b> to <b>June 1, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 1 1961</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>Laurence C. Post</b>					M.D. <b>Laurence C. Post</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6-5-61</b>					
22c. PHYSICIAN'S NAME (Type) <b>LAURENCE C. Post</b>					22d. ADDRESS <b>6805-York Rd.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 6, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City, town or county) <b>Baltimore, Maryland</b>		(State)						
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>					ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JUN 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>					

(M)

Baltimore

Baltimore

Town

Baltimore 12

Good Government Home

612 W. Wood

JOHN EDWARD GULLING

June 1,

82

July 1, 1938

x

White

Male

Former - retired

American Can Co. Maryland

USA

William W. Gulling

James W. Gulling

Family Records

212-04-2022

Home

Baltimore, Maryland

John Edward Gulling

June 6, 1941

Burial

John Burns' Sons, Towson, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6574

## CERTIFICATE OF DEATH

Reg. Dist. No. 06558

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>1 YR.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RIDGEWAY MANOR</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>T.</b> Last <b>SULLIVAN</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>9</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 16, 1873</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>MICHAEL SHEEHAN</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE NILAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>NORBERT J. SULLIVAN</b>		Address <b>ELLICOTT CITY, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma right breast</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 50</b> , to <b>6/9</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>6/8</b> , 19 <b>61</b> , and that death occurred at <b>1:30 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3629 Edmondson Ave., Balto-29-Md</b> DATE SIGNED <b>6/10/61</b>			
ACTUAL SIGNATURE <b>Thos. E. Roach</b>		M.D. <b>Thos. E. Roach, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/12/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. MEARS &amp; SON</b>		ADDRESS <b>805 N. CALVERT ST.</b>	
24a. REC'D BY REGISTRAR <b>JUN 13 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is oriented horizontally but contains vertical text labels for various fields.

NAME OF DECEASED: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_

PLACE OF DEATH: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PLACE OF BIRTH: \_\_\_\_\_

SEX: \_\_\_\_\_

AGE: \_\_\_\_\_

EDUCATION: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

RELIGION: \_\_\_\_\_

DATE OF MARRIAGE: \_\_\_\_\_

PLACE OF MARRIAGE: \_\_\_\_\_

NAME OF SPOUSE: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_

PLACE OF DEATH: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PLACE OF BIRTH: \_\_\_\_\_

SEX: \_\_\_\_\_

AGE: \_\_\_\_\_

EDUCATION: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

RELIGION: \_\_\_\_\_

DATE OF MARRIAGE: \_\_\_\_\_

PLACE OF MARRIAGE: \_\_\_\_\_

NAME OF SPOUSE: \_\_\_\_\_



Arthur S. Kraus

VR A15 (4)  
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WILLIAM H. GUNNING

NEW YORK

U. S. DEPT. OF JUSTICE

BALTIMORE, MARYLAND

JOHN HANSEN

CLINICAL RECORD, Vol. 1, Baltimore, Md.

CHRONOLOGICAL

SECRET

CHRONOLOGICAL

SECRET

WILLIAM H. GUNNING, M.D.

BALTIMORE, MARYLAND

WILLIAM H. GUNNING, M.D.  
BALTIMORE, MARYLAND  
CLINICAL RECORD, Vol. 1, Baltimore, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
06560											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>EDGEMERE</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>774 S. Woodington Rd</b> d. STREET ADDRESS <b>Baltimore-29, Maryland 3V01-4</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Shannon</b> Middle <b>Lee</b> Last <b>Trainer</b>				4. DATE OF DEATH Month <b>6</b> Day <b>17</b> Year <b>1961</b>							
5. SEX <b>M</b>		6. COLOR OR RACE <b>Wh.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 13, 1926</b>		9. AGE (In years last birthday) <b>35</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>17</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Policeman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles P. Trainer</b>				14. MOTHER'S MAIDEN NAME <b>Grace L. ?</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW # II</b>				16. SOCIAL SECURITY NO. <b>No</b>				17. INFORMANT <b>Mrs. Mildred J. Trainer-774 S. Woodington Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>974X</b> DUE TO <b>Hanging</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Apparently hanged self from beam on pier</b>							
20c. TIME OF INJURY Month, Day, Year <b>6/17/61</b> Hour a.m. <b>9:00</b> p.m. <b>10:00</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>dock</b>		20f. (City or town) <b>Edgemere</b> (County) <b>Md</b> (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>W. Bradley King Jr.</b>				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>6/17/61</b>			
EXAMINER'S NAME (Type) <b>W. Bradley King Jr.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-20-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR <b>Tom J. Lickner &amp; Sons</b>				24a. REC'D BY REGISTRAR <b>North &amp; Penna Balto 17, Md</b>				24b. REGISTRAR'S SIGNATURE <b>James L. Travis</b>			

02240

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE OF

U.S.A.

DEPT. OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6577

06561

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>600 Martin Blvd.</u>				d. STREET ADDRESS <u>600 Martin Blvd.</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Samuel Newton Truitt</u>		First Middle Last		<b>4. DATE OF DEATH</b> <u>June 17 19 61</u>		Year			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8-26-1888</u>			
<b>9. AGE</b> (In years last birthday) <u>72</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Carpenter Ret.</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Maryland</u>					
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>USA</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>					
<b>13. FATHER'S NAME</b> <u>Lorenzo Truitt</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Rebecca</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>Dorothy C. Truitt</u>					
<b>17. INFORMANT</b> <u>same</u>				Address					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>602X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cor pulmonale</u> (a), stating the underlying cause last. DUE TO (c) <u>Renal calculus (aggravating factor)</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>6/17</u> 19<u>61</u>, to <u>6/19</u> 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>6/17</u> 19<u>61</u>, and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <u>D. Clark Holmes</u>				<b>22b. DATE SIGNED</b> <u>6/19/61</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Dr. A. Clark Holmes</u>				<b>22d. ADDRESS</b> <u>8019 Philadelphia Road, Baltimore 6, Maryland</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u>		<b>23b. DATE THEREOF</b> <u>6-21-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Moreland Mem. Park</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, Md.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Leonard J. Ruck</u>				<b>25a. REC'D BY REGISTRAR</b> <u>DATE JUN 20 '61</u>					
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanna</u>									

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

6578

06562

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>329 Harlem Lane</u> <u>Caton Ridge Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3934 Norfolk Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary Sidney Turpin</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>June 6, 1961</u> Month Day Year			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 13, 1874</u> 87 yrs.	
<b>9. AGE</b> (In years last birthday) <u>87</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days		<b>11. IF UNDER 24 HRS.</b> Hours Min.		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Retired</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Illinois</u>	
<b>13. FATHER'S NAME</b> <u>Owen Troy Wharton</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Angeona ?</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b>			
<b>17. INFORMANT</b> <u>Mr. Sidney G. Turpin-3934 Norfolk Avenue</u>				Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Broncho pneumonia Bilateral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>by</u> (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>7/12/57</u> to <u>6/6</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/19</u> , 19 <u>61</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Cliff Ratliff, Jr.</u> M.D.				<b>22b. DATE SIGNED</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Cliff Ratliff, Jr.</u>	
<b>22d. ADDRESS</b> <u>4605 Edmondson Avenue</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>6-8-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, Maryland</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm J. Tucker &amp; Sons</u>				<b>25a. REC'D BY REGISTRAR</b> <u>North &amp; Penna Aves</u> <u>Balto 17 recd</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06563

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Rosedale</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Rosedale</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5822 Shadyside Lane (Shady Spring Ave.)</b>			d. STREET ADDRESS <b>5822 Shadyside Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>JOSEPH CHARLES VLACH (Vlach)</b>			4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>19 61</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 16, 1925</b>		9. AGE (In years last birthday) <b>35 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Department Store</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Joseph James Vlach</b>		
14. MOTHER'S MAIDEN NAME <b>Josephine Catherine Martin</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW II</b>		
16. SOCIAL SECURITY NO. <b>219-10-9626</b>			17. INFORMANT <b>Joseph J. Vlach 5822 Shady Spring Ave.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTORY <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>W. Bradley King, Jr., M.D.</b>		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>		Address (Street, city, town, or county) <b>Baltimore-Maryland</b>		DATE SIGNED <b>6/23/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-26-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	22d. LOCATION (City, town, or country) (State) <b>Baltimore-Maryland</b>		
23. FUNERAL DIRECTOR <b>Philip E. Cvach 1211 Chesaco Ave. Zone 6</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>JUN 27 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 12 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06564

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>2yr7mth18dys</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1214 Riverside Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Bridgette</b> Last <b>Vogelsang</b>		4. DATE OF DEATH Month <b>6</b> Day <b>11</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 17, 1879</b>
9. AGE (In years lost birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>11</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jacob Hoben</b> (James Hoben)		14. MOTHER'S MAIDEN NAME <b>Brigette Rockford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 5, 1961</b> to <b>June 11, 1961</b> that (I) (we) last saw the deceased alive on <b>June 11, 1961</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Blanca Gimenez</b>		22b. DATE SIGNED <b>June 11/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Blanca Gimenez</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-15-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Balto Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>McCally Funeral Home</b>		25a. RECD BY REGISTRAR <b>DATE JUN 13 '61</b>	
ADDRESS <b>130 E. Fort Ave</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6581

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06565

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>				c. LENGTH OF STAY IN 1b <b>5 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1111 Elmridge Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Gordon A. Voyce</b>				4. DATE OF DEATH <b>June 2, 1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1907</b>		9. AGE (In years last birthday) <b>54</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinest</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hackert Const.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Voyce</b>				14. MOTHER'S MAIDEN NAME <b>Bridgid T. Herbert</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-10-9376</b>		17. INFORMANT <b>Margaret E. Voyce</b> Address <b>1111 Elmridge Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung, right (post-operative 2 months)</b> 163X DUE TO (b) <b>Operative 2 months</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							INTERVAL BETWEEN ONSET AND DEATH <b>8 mo</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 20, 1959</b> to <b>June 2, 1961</b> that (I) (we) last saw the deceased alive on <b>June 2, 1961</b> and that death occurred at <b>12:45 M.</b> from the causes and on the date stated above.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. SIGNATURE <b>R. M. Cunningham M.D.</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>Raymond M. Cunningham M.D.</b>	
22d. ADDRESS <b>Medical Arts Bldg.</b>				22e. ADDRESS		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/5/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ambrose Inc. 1328 Sulphur Spring Rd.</b>				25a. REC'D BY REGISTRAR <b>JUN 6 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

CHIEF CLERK

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Amrose Inc. 1338 Fifth Ave. N.Y.C. 100

Initial

6/5/51

at Central Cemetery, Baltimore, Maryland

Raymond W. Cunningham M.D. Medical Director

*[Faint, mostly illegible text in the main body of the document, possibly bleed-through from the reverse side.]*

Residence

Phone

2nd

Address

Married

Married

CERTIFICATE OF DEATH

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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH  
 06566

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b> c. LENGTH OF STAY IN 1b <b>33 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>5408 BIDDISON AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>FRANK MILTON WAGNER</b> First Middle Last				4. DATE OF DEATH Month <b>6</b> Day <b>14</b> Year <b>1961</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-10-1899</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab driver</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>MICHAEL (?)</b>				14. MOTHER'S MAIDEN NAME <b>PAULINE (?)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>213-18-6054</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of sigmoid</b> <b>153.8</b> DUE TO <b>colon with metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>1 year</b> (c) <b>1 year</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary tuberculosis. Emphysema</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>002x</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5.13.1961</b> to <b>6.14.1961</b> , that (I) (we) last saw the deceased alive on <b>6.14.1961</b> , and that death occurred at <b>1:56 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W. Newcomer</b>				22b. DATE SIGNED <b>6.14.1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>				22d. ADDRESS <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/17/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Weber &amp; Sons Inc</b> ADDRESS <b>401 S. Chester St.</b>				25a. REC'D BY REGISTRAR <b>JUN 19 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 23b, telephone call from Tickner's Office

6583

06567

6/9/61.c

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>House in the Pines-16 Fusting Avenue</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>1200 Biddle Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Nannette E. Waltemeyer</u>				<b>4. DATE OF DEATH</b> <u>June 8, 1961</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Nov. 3, 1887</u>	
<b>9. AGE</b> (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerk-Retired</u>					
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>John T. Waltemeyer</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary E. ?</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>705-05-3112</u>			
<b>17. INFORMANT</b> <u>Mrs. Leo Griggs-1200 Biddle Place</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cerebro Vascular Syndrome</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) } DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1950</u> , <b>19</b> <u>6/8</u> , <b>19</b> <u>61</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>6/8</u> , <b>19</b> <u>61</u> , <b>and that death occurred at</b> <u>5A</u> , <b>from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <u>Edward S. Kallins</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>L Edward S. Kallins</u> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>4300 Liberty Heights Avenue</u> <b>22b. DATE SIGNED</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>6-17-61</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park Cemetery</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, Maryland</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>North &amp; Anna does</u> <u>May Tickner, Jr.</u> <u>Balt-17114</u> <b>25a. REC'D BY REGISTRAR</b> <u>  </u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u> <u>  </u> <b>DATE</b> <u>JUN 9 '61</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

6584

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06568

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCESS ANNE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		d. STREET ADDRESS <b>19X-2</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDNA CROSWELL WHITE</b>		4. DATE OF DEATH Month Day Year <b>JUNE 8 1961</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-28-1884</b>
9. AGE (In years lost birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U-S</b>	
13. FATHER'S NAME <b>WILLIAM W. CROSWELL</b>		14. MOTHER'S MAIDEN NAME <b>LAVINA HASTINGS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Frank L. Smith Jr. - Cockeysville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension Arterio sclerotic Cardio</b> DUE TO (c) <b>Vascular disease</b> 10 years. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-6</b> 19 <b>61</b> , to <b>6-7</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>6-7</b> 19 <b>61</b> , and that death occurred at <b>7:25</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter T. Kees</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>6/8/61</b> 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>		22d. ADDRESS <b>COCKEYSVILLE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>June 11, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>All Saints Churchyard</b>		23d. LOCATION (City, town, or county) (State) <b>Princess Anne, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc. 1217 St. Paul St.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 9 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
06569

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Delaware</b> b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>6-1/2 HOURS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Seaford</b>			
d. STREET ADDRESS <b>46X -3</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>E.</b> Last <b>WHITE</b>				4. DATE OF DEATH Month <b>June</b> Day <b>2,</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>9-7-90</b>	
9. AGE (in years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Produce</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>Salisbury, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Oliver S. White</b>				14. MOTHER'S MAIDEN NAME <b>Betsy Jane Fletcher</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW-1</b>				16. SOCIAL SECURITY NO. <b>226-28-9956</b> 17. INFORMANT <b>Mrs. Sara L. Beard (Sister) P. Box #302 Seaford Del.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410X EDEMA OF THE LUNGS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARDIAC HYPERTROPHY AND DILATION</b> DUE TO (c) <b>AORTIC AND MITRAL INSUFFICIENCY</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>  <b>UNKNOWN</b>  <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>4. PASSIVE CONGESTION LUNGS, LIVER AND SPLEEN</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 2, 1961</b> to <b>June 2, 1961</b> that <input type="checkbox"/> (we) last saw the deceased alive on <b>June 2, 1961</b> , and that death occurred at <b>7:00 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Norman P. Jones</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/3/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>NORMAN P. JONES, M. D.</b>				22d. ADDRESS <b>VAH, BALTO. MD. FT HOWARD DIV.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Jun. 6, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shad Point Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>R.D.# Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Holloway &amp; Co. Funeral Home, Salisbury, Md.</b>				25a. REC'D BY REGISTRAR <b>JUN 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

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OSCAR B. WILSON

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OSCAR B. WILSON

22-42-2222

June 6, 1961

WILSON, OSCAR B.

WILSON, OSCAR B.

OSCAR B. WILSON

June 2, 1961

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6586

## CERTIFICATE OF DEATH

06570

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTO.</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>CATONSVILLE</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CATON RIDGE HOME</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CATONSVILLE</u> d. STREET ADDRESS <u>1400 CHALFONTE DR.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) <u>JOSEPH L. WHITTY</u>		<b>4. DATE OF DEATH</b> Month <u>6</u> Day <u>15</u> Year <u>1961</u>		<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6/13/88</u>		<b>9. AGE</b> (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Police ret.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>md</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>NICHOLAS WHITTY</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>MARK E. CARRIGAN</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> Address					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) <u>age</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Bed Sores</u>																<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 hr</u>					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)																					
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>5/22, 1961</u> to <u>6/15, 1961</u> , that (I) (we) last saw the deceased alive on <u>6/14, 1961</u> , and that death occurred at <u>9:25 PM</u> , from the causes and on the date stated above.																					
<b>22a. SIGNATURE</b> <u>Curt Rounts</u> M.D.										<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			<b>22b. DATE SIGNED</b>								
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>4605 EDMONDSON AVE</u>										<b>22d. ADDRESS</b> <u>BALTO 29, md.</u>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>6/19/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lorraine</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Woodlawn Md.</u>											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Donna Stott + son 28</u>																					
<b>25a. REC'D BY REGISTRAR</b>								<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Hanna</u>													
<b>DATE</b> <u>JUN 20 '61</u>																					

TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

(M)

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00550

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ESTIMATE OF DEATH

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VS. AISME  
5M 9/60

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Providence Road near Loch Raven</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Baltimore</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> d. STREET ADDRESS <b>8700 Loch Bend Drive.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <b>JOHN WILLIAM WICK</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>June 24 19 61</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>March 1, 1904</b> <b>57 yrs.</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>  <b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>John Wick</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Helen White</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>216-03-4030</b> <b>17. INFORMANT</b> <b>Robert L. Johnson, 3022 Overland Avenue</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot Wound of Abdomen.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <b>219. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>  <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in abdomen.</b>		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <del>XXXX</del> <b>6/24</b> 19 <b>61</b> p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Road</b> <b>20f. (City or town) (County) (State)</b> <b>Towson Baltimore Md.</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>.</b> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>ACTUAL SIGNATURE</b> <i>Charles S. Petty</i> <b>M.D.</b> <b>DATE SIGNED</b> <b>6/25/61</b> <b>EXAMINER'S NAME (Type)</b> <b>Charles S. Petty, M.D.</b> Address (Street, city, town, or county) _____			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>6-28-61</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Moreland Memorial</b>		<b>22d. LOCATION (City, town, or country) (State)</b> <b>Baltimore</b>	
<b>23. FUNERAL DIRECTOR</b> <b>Wm. Cook-Blight, Inc., 6009 Harford Road</b>		<b>24a. REC'D BY REGISTRAR</b> <b>JUN 28 '61</b> <b>DATE</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Harris</i>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6585

06572

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>607 Piccadilly Road</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE <b>Mass.</b> <span style="float: right;">b. COUNTY</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newton Center</b> d. STREET ADDRESS <b>83 Norwood Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>LOUISE SLAYTON WILLARD</b>			<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>15</b> Year <b>1961</b>				
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>May 20, 1886</b>		<b>9. AGE</b> (In years last birthday) <b>75</b> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Mass.</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			<b>13. FATHER'S NAME</b> <b>John Charles Fremont Slayton</b>				
<b>14. MOTHER'S MAIDEN NAME</b> <b>Gertrude Lancaster</b>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>				
<b>16. SOCIAL SECURITY NO.</b> <b>None</b>			<b>17. INFORMANT</b> <b>Family Records</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Decompensative Cardio Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>May 28, 1961</b> to <b>June 15, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 15, 1961</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Laurence C. Post</b>			<b>22b. DATE SIGNED</b> <b>6-16-61</b>				
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>LAURENCE C. Post</b>			<b>22d. ADDRESS</b> <b>6805 York Rd. Baltimore 12 Md</b>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>		<b>23b. DATE THEREOF</b> <b>June 16, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Short &amp; Williamson Funeral Home</b>			
<b>23d. LOCATION</b> (City, town or county) <b>Boston, Mass</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John Burns' Sons, Towson, Maryland</b>					
<b>25a. REC'D BY REGISTRAR</b> <b>JUN 23 1961</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Thomas</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

(M)

Baltimore

Maryland

Townson

Newton Center

607 Pricedville Road

83 No Wood Road

LOUISE CLAYTON WILLARD

June 15,

61

x

Female White

x

May 20, 1986

75

Housewife

Own Home

Maryland

USA

John Charles Fremont Clayton

Gertrude Labovitz

None

None

Family Records

(1)

John Burns' Son, Townson, Maryland  
Removed June 10, 1961 Short & Williamson Funeral Home Boston, Mass

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
06589 06573									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Md.</b>				
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS <b>Greenspring Ave., Owings Mills, Md. Greenspring Ave. Rt #1</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Clement Vivian Wolfe</b>					4. DATE OF DEATH <b>June 29, 19 61</b>				
5. SEX <b>Male</b>					6. COLOR OR RACE <b>White</b>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>May 2, 1903</b>				
9. AGE (In years last birthday) <b>58</b> yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Veterans Admin.</b>				
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Louis Wolfe</b>					14. MOTHER'S MAIDEN NAME <b>Izetta Blevins</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes W.W. 11</b>					16. SOCIAL SECURITY NO. <b>None</b>				
17. INFORMANT <b>Mrs. Earline B. Wolfe, Greenspring Ave.</b>					Address <b>Owings Mills, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> 420.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aricular Fibrillation</b> DUE TO (c) <b>Angina Pectoris</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>none</b>					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>none</b> 19 p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>none</b>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>					20f. (City or town) (County) (State) <b>none</b>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ACTUAL SIGNATURE <b>D.D. Caples</b> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <b>Dr. D.D. Caples, Reisterstown, Md.</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>7-1-61</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>July 3, 1961</b>				
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>					22d. LOCATION (City, town, or country) (State) <b>Baltimore, Md.</b>				
23. FUNERAL DIRECTOR <b>Frank H. Newell, Baltimore, Md.</b> ADDRESS									
24a. REC'D BY REGISTRAR <b>DATE JUL 6 '61</b>					24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				

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(C)

(S)

(T)

(U)

(V)

(W)

(X)

(Y)



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6590

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06574

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>7 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Nursing Home</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3815 W. Cold Spring Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jennie</b> Middle <b>Foulac</b> Last <b>Wood</b>				4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 2, 1876</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>13</b> Hours <b>13</b> Min. <b>4</b>		IF UNDER 24 HRS. Hours <b>13</b> Min. <b>4</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School- teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Thomas Wood</b>				14. MOTHER'S MAIDEN NAME <b>Alice Roberts</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. R.J. Beggs 3501 St. Paul St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Disease</b> 334X DUE TO <b>with apoplexy about 8 years</b> (b) <b>3 Semblity</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>June 13, 1961</b> to <b>June 13, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 13, 1961</b> , and that death occurred at <b>1372</b> from the causes and on the date stated above. 22a. SIGNATURE <b>Dr. Paul M. Byerly</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <b>Dr. Paul M. Byerly</b> 22d. ADDRESS <b>3033 W. North Ave.</b> 22b. DATE SIGNED							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 16, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John O. Mitchell &amp; Sons, Inc.</b> <b>1900 Eutaw Place</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

M

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MA

(1)

RECEIVED

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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

06575

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. LENGTH OF STAY IN 1b <u>3 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>				d. STREET ADDRESS <u>1106411eghany Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Caroline Roberta Woods</u>				4. DATE OF DEATH Month Day Year <u>June 28 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6, 1887</u>	
9. AGE (In years lost birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.		IF UNDER 24 HRS. Hours <u>11</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NO</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>J. Robert Woods</u>				14. MOTHER'S MAIDEN NAME <u>Alice Spileker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Emmett Woods per Dr. Heaps R.N.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>1 year</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 28, 1961</u> to <u>June 28, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 28, 1961</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Franklin E. Leslie</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Franklin E. Leslie</u>				22d. ADDRESS <u>2429 N. Charles ST</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 1, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Maryland</u> ADDRESS				25a. REC'D BY REGISTRAR <u>JUL 5 '61</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Wm. S. Thomas</u>	

100-100000

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
6592													
CERTIFICATE OF DEATH													
06576													
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>3 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21 (Hyde Park 21)</b> d. STREET ADDRESS <b>1448 Galena Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>ALFRED J. WOOLLEY</b>						4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>19 61</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 19, 1907</b>		9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Alfred Woolley</b>						14. MOTHER'S MAIDEN NAME <b>Louise Wagner</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW II</b>						16. SOCIAL SECURITY NO. <b>216-07-5391</b>						17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>Fort Howard Division</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EMPHYSEMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>241x</b> (b) <b>ASTHMA</b> DUE TO (c) <b>UNKNOWN</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>ARTERIOSCLEROTIC HEART DISEASE - DURATION UNKNOWN</b>													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>10:45</b>													
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>													
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)													
20f. (City or town) (County) (State)													
21. I certify that <del>to</del> (this hospital) attended the deceased from <b>June 16, 1961</b> , to <b>June 19, 1961</b> that <del>it</del> (we) last saw the deceased alive on <b>June 19, 1961</b> , and that death occurred at <b>10:45 A.M.</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>Thomas F. Crahan</b> M.O. 22c. PHYSICIAN'S NAME (Type) <b>Thomas F. Crahan, M.D.</b>													
22b. DATE SIGNED <b>6/19/61</b>													
22d. ADDRESS <b>VAH, Baltimore 18, Md.</b> <b>Fort Howard Division</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>													
23b. DATE THEREOF <b>6-22-61</b>													
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>													
23d. LOCATION (City, town or county) (State) <b>Baltimore 28, Maryland</b>													
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14, Md.</b>													
25a. REC'D BY REGISTRAR <b>JUN 21 '61</b>													
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06577

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>6307 Bellona Ave</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Rose</b> Middle <b>Lee</b> Last <b>Wright</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 4 1898</b>
9. AGE (In years last birthday) yrs. <b>62</b>		IF UNDER 1 YEAR Months <b>20</b> Days <b>19</b> Hours <b>61</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Balto Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry DeSheilds Seim</b>		14. MOTHER'S MAIDEN NAME <b>Josephine B Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Edwin F. Wright</b>		Address <b>6307 Bellona Ave</b>	
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mel.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 6, 1960</b> , to <b>June 20, 1961</b> , that I last saw the deceased alive on <b>June 20, 1961</b> , and that death occurred at <b>4:15 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Laurence C. Post</b>		M.D. <b>6805 York Rd.</b>	
PHYSICIAN'S NAME (Type) <b>LAURENCE C. POST</b>		DATE SIGNED <b>6-20-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 23 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Carmichael</b>		ADDRESS <b>204 Ridgewood Ave</b>	
24a. REC'D BY REGISTRAR <b>JUN 22 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH																			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
06578																			
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>														
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CHASE MD.</b>					c. LENGTH OF STAY IN 1b <b>13 YRS.</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CHASE MD.</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Box 398 North River Drive #20</b>					d. STREET ADDRESS <b>Box 398 North River Drive #20</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>BARBARA G. ZOELLER</b>					4. DATE OF DEATH Month <b>6</b> Day <b>14</b> Year <b>1961</b>														
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/19/1886</b>		9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>					11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>CHRISTIAN HEARN</b>					14. MOTHER'S MAIDEN NAME <b>SALLY RHODES</b>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>					16. SOCIAL SECURITY NO. <b>NONE</b>					17. INFORMANT <b>William. ZOELLER</b>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-Vascular Disease</b> 443X DUE TO (b) <b>Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>										INTERVAL BETWEEN ONSET AND DEATH <b>—</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>6/16/61</b> Address (Street, city, town, or county)																			
ACTUAL SIGNATURE <b>M.B. Davis</b>					M.D. <b>M.B. DAVIS MD</b>														
EXAMINER'S NAME (Type) <b>M.B. DAVIS MD</b>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>					22b. DATE THEREOF <b>6/17/61</b>					22c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEM PARK</b>					22d. LOCATION (City, town, or country) (State) <b>BALTIMORE MARYLAND</b>				
23. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>					ADDRESS <b>7401 Belair Rd #6</b>					24a. REC'D BY REGISTRAR <b>6</b>					24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hearn</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2 &amp; 12 Film G288 6/15/61 iwk

6595

## CERTIFICATE OF DEATH

Reg. Dist. No.

06579

1. PLACE OF DEATH a. COUNTY <b>Balto. 28, Maryland</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Summit Nursing Home</b>				d. STREET ADDRESS <b>215 W. Lorraine Ave.</b> <b>Summit &amp; Smithwood Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Annie C. Zorio</b>				4. DATE OF DEATH <b>June 8, 1961</b> <b>19</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 24, 1884</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Cefalu' Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Santo Catanese</b>		14. MOTHER'S MAIDEN NAME <b>Teresa Rosso</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Annie L. Salmeri</b> <b>3104 W. Garrison Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arterio Sclerosis</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Residual of Multiple Strokes</b>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>MD</b> <b>6/8/61</b> (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <b>6/7/61</b> to <b>6/8/61</b> , that I last saw the deceased alive on <b>6/7/61</b> , 19 <b>61</b> , and that death occurred at <b>2:50 A.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>1303 Frederick Rd</b> <b>Catonsville 28md</b> DATE SIGNED <b>6/9/61</b>			
ACTUAL SIGNATURE <b>W. E. Mc Grath</b> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/14/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Old Frederick Road</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Farace Inc.</b> <b>712-14 E. North Ave.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>JUN 9 '61</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6596 Item 2 Film G208 6/15/61 iwk 06580											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO. CATONSVILLE</u> 60 YRS. c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Josephs Conv. Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> (30) Md. 3V01-4 d. STREET ADDRESS <u>1227 TUGWELL DR</u> 1227 Carroll St. a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Bois Zwickas</u>			4. DATE OF DEATH <u>June 2</u> 1961			5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>DEC. 8, 1891</u> 69 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>LITHUANIA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO. <u>215-14-9369 MR. Joseph DASH</u> 337 Whitfield Rd.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular Disease</u> (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cerebral Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>6 yrs</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 12, 1961</u> to <u>June 2, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 2, 1961</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Justinas Kudirka</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Justinas KUDIRKA</u>						22d. ADDRESS <u>2151 Wilkens ave, Balt. Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>6-6-61</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cmt</u>			23d. LOCATION (City, town or county) (State) <u>BALTIMORE Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dabrowski</u> ADDRESS <u>284 E. BALTIMORE ST.</u>						25a. REC'D BY REGISTRAR DATE <u>JUN 12 '61</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

VR A15 (4)  
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